INITIAL REVIEW DRAFT

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Iowa Health and Wellness Plan Evaluation Interim Summative Report

Elizabeth Momany
*Associate Research Scientist**

Peter Damiano
*Director**
*Bernstein Professor, College of Dentistry***

Suzanne Bentler
*Assistant Research Scientist**

Susan McKernan
*Assistant Professor, Preventive & Community Dentistry***

Dan Shane
*Assistant Professor, Health Management and Policy****

Phuong Nguyen
*Associate Professor, Urban and Regional Planning*****

Brooke McInroy
*Survey Research Manager**

Tessa Heeren
*Research Assistant**

Jason Wachsmuth
*Research Assistant**

Mark Pooley
Research Assistant

**University of Iowa Public Policy Center*
***University of Iowa College of Dentistry and Dental Clinics*
****University of Iowa College of Public Health*
*****University of Iowa College of Liberal Arts and Sciences*

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Executive Summary

Below are the research questions and associated hypotheses for the evaluation of the Iowa Wellness Plan with a summary of the results for comparisons with income eligible Medicaid members.

Question 1 What are the effects of the Wellness Plan on member access to care?

Hypothesis 1.1

Iowa Wellness Plan members will have equal or greater access to primary care and specialty services.

Most measures within the hypothesis indicated that IWP members had equal access to primary care and specialty services.

Hypothesis 1.2

Iowa Wellness Plan members will have equal or greater access to preventive care services.

Preventive care measures show that IWP members did have equal or greater access to preventive services. The only exception to this finding was in cervical cancer screening where rates were higher for women who were income eligible for Medicaid.

Hypothesis 1.3

Iowa Wellness Plan members will have equal or greater access to mental and behavioral health services.

Results indicate that IWP members had a lower need for mental and behavioral health services as well as a lower unmet need for these services.

Hypothesis 1.4

Iowa Wellness Plan members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.

Though IWP member access to care seems equal to Medicaid member access to care, utilization of the ED for non-emergent care is lower.

Hypothesis 1.5

Iowa Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.

IWP members do have lower barriers to care from transportation than Medicaid members despite the fact that they had a higher unmet need for transportation to health care.

Hypothesis 1.6

Iowa Wellness Plan members aged 19-20 years will have equal or greater access to EPSDT services.

This hypothesis was not tested due to the low numbers of members 19-20 years of age. Many Medicaid members are able to remain in the Medicaid program during transition to adulthood at 21.

Question 2 What are the effects of the Iowa Wellness Plan on member insurance coverage gaps and insurance service when their eligibility status changes (churning)?

Hypothesis 2.1

Iowa Wellness Plan members will experience equal or less churning

Originally, IWP resulted in approximately 40,000 people losing coverage through the elimination of the IowaCare program, however for those who remained in IWP access to services and providers was expanded. Once the program stabilized the amount of churning was comparable between IWP and Medicaid.

Hypothesis 2.2

Iowa Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.

Some IWP members did churn into the Medicaid program, presumably due to a decrease in income. However, we were unable to follow members who lost eligibility over time. More information regarding access to care following disenrollment is contained in the HBI report.

Survey questions did address continuity of care when changing plans. Approximately half of the members who identified as having a personal doctor or nurse were able to retain a continuous relationship with that provider when changing plans and approximately 15% were able to gain a personal doctor or nurse when changing plans.

Question 3 What are the effects of the Iowa Wellness Plan on member quality of care?

Hypothesis 3.1

Iowa Wellness Plan members will have equal or better quality of care.

Though most administrative measures related to quality of care were removed due to small numbers, the survey results indicated that IWP members were more likely to receive a flu shot than Medicaid members.

Hypothesis 3.2

Iowa Wellness Plan members will have equal or lower rates of hospital admissions.

IWP members experienced higher rates of hospitalization than Medicaid members, however, this must be interpreted with care, as we are unable to risk adjust the IWP population. This population is older and more likely to be chronically ill than the population of income eligible Medicaid members.

Hypothesis 3.3

Iowa Wellness Plan members will report equal or greater satisfaction with the care provided.

IWP members generally reported equal or higher levels of satisfaction with care than Medicaid members.

Question 4 What are the effects of the Iowa Wellness Plan on the costs of providing care?

Hypothesis 4.1

The cost for covering Iowa Wellness Plan members will be comparable to the predicted costs for covering the same expansion group in the Medicaid State Plan.

PMPM costs for IWP members were at or below the costs for Medicaid State Plan members during the previous waiver period. However, cost was not evaluated during the most recent waiver period as IWP and Medicaid State Plan members were covered by capitation, making the state's cost for their care comparable.

Question 5 What are the effects of the premium incentive and copayment disincentive programs on Iowa Wellness Plan enrollees?

Hypothesis 5.1

The premium incentive for the Iowa Wellness Plan enrollees will not impact the ability to receive health care.

The role of premium incentive impacting ability to receive health care was not addressed within the evaluation, however, less than ½ of members were aware of the premium incentive and less than 30% were worried a great deal about paying a premium. Additionally, the need for paying a premium was not mentioned as one of the top reasons for not obtaining a medical or dental exam.

Hypothesis 5.2

The majority of IWP members will complete the healthy behaviors and therefore not have to pay a premium incentive or be disenrolled.

A majority of IWP members were not disenrolled, though the reasons for this are unclear as definition, completion and documentation of the healthy behaviors has changed over time.

Hypothesis 5.3

The copayment for inappropriate emergency department (ED) use for the Iowa Wellness Plan enrollees will not pose an access to care barrier.

Though the impact of the copayment on access to care was not assessed, less than 35% of IWP members were aware of the ED copayment requirement and less than ½ felt it would be very easy to know what constitutes an emergency condition.

Hypothesis 5.4

In year two and beyond, the utilization of an annual exam will be higher than in the first year of the program.

The utilization of annual exam increased over the 4 years of the IWP program.

Hypothesis 5.5

In year two and beyond, the utilization of smoking cessation services will be higher than in the first year of the program.

The increase in smoking cessation services was not addressed.

Question 6 What is the adequacy of the provider network for Iowa Wellness Plan enrollees as compared to those in the Iowa Medicaid State Plan?

Hypothesis 6.1

Iowa Wellness Plan members will have the same access to an adequate provider network as members in the Medicaid State Plan.

Iowa Wellness Plan members did have equal or greater access to an adequate provider network as compared to those in the Iowa Medicaid State Plan.

Background

There were originally two components to the Iowa Health and Wellness Plan (IHAWP), a bipartisan solution to expand health care to low-income adult Iowans not categorically eligible for Medicaid: Wellness Plan (WP), a program operated by the Iowa Department of Human Services that provided health coverage for uninsured Iowans from 0-100% of the Federal Poverty Level (FPL) and Marketplace Choice (MPC), a premium support program for Iowans from 101-133% FPL. More information regarding the formulation and implementation of IHAWP can be found online at http://dhs.iowa.gov/ime/about/initiatives/iowa-health-and-wellness-plan.

IHAWP was modified in significant ways in the first two years (**Table 1**), affecting the program design, the network of providers from whom members could receive services, and potentially the outcomes evaluated in this report. The first major change occurred when CoOportunity Health withdrew as a Qualified Health Plan (QHP) option for MPC members at the end of November 2014.[1] Approximately 9,700 CoOportunity Health members were automatically transitioned to Medicaid providers on December 1, 2014 through MediPASS (primary care case management [PCCM] program), Meridian (HMO), or traditional Medicaid (fee-for-service [FFS] payment mechanism); however, they retained their designation as MPC members. IHAWP members who were not in CoOportunity Health remained in Coventry, the other QHP. However, Coventry was not willing to cover MPC members transitioning from CoOportunity Health.

Effective January 1, 2016 MPC members were rolled into WP and the Iowa Health and Wellness Plan (IHAWP) became Iowa Wellness Plan (IWP) covering Iowans not categorically eligible for Medicaid with incomes from 0-133% FPL through one program.

Beginning April 1, 2016, Iowa implemented mandatory managed care service delivery. The majority of Medicaid members, including IHAWP members, were enrolled with one of three managed care organizations (MCOs). Due to a three-month implementation delay, IHAWP members enrolled with a QHP were placed into the traditional Medicaid FFS program effective December 31, 2015, until the Medicaid Managed Care Organizations (MCOs) were able to begin accepting members on April 1, 2016.

Members were enrolled with one of three MCOs: Amerigroup Iowa, Inc.; AmeriHealth Caritas, Inc.; or UnitedHealthcare Plan of the River Valley, Inc. This report provides the outcome results for the two years in which statewide managed care was implemented. However, due to the late start members were only in the MCO model for nine months during CY 2016. The results for previous years are contained in a number of reports and articles that can be accessed at http://ppc.uiowa.edu/health/study/evaluation-iowas-medicaid-expansion-iowa-health-and-wellness-plan.

[1] Iowa Marketplace Choice Plan Changes. Iowa Department of Human Services. November 2014. Available at: https://dhs.iowa.gov/sites/default/files/CoOpTransition_FAQ_11052014.pdf. Accessed July 2, 2015.

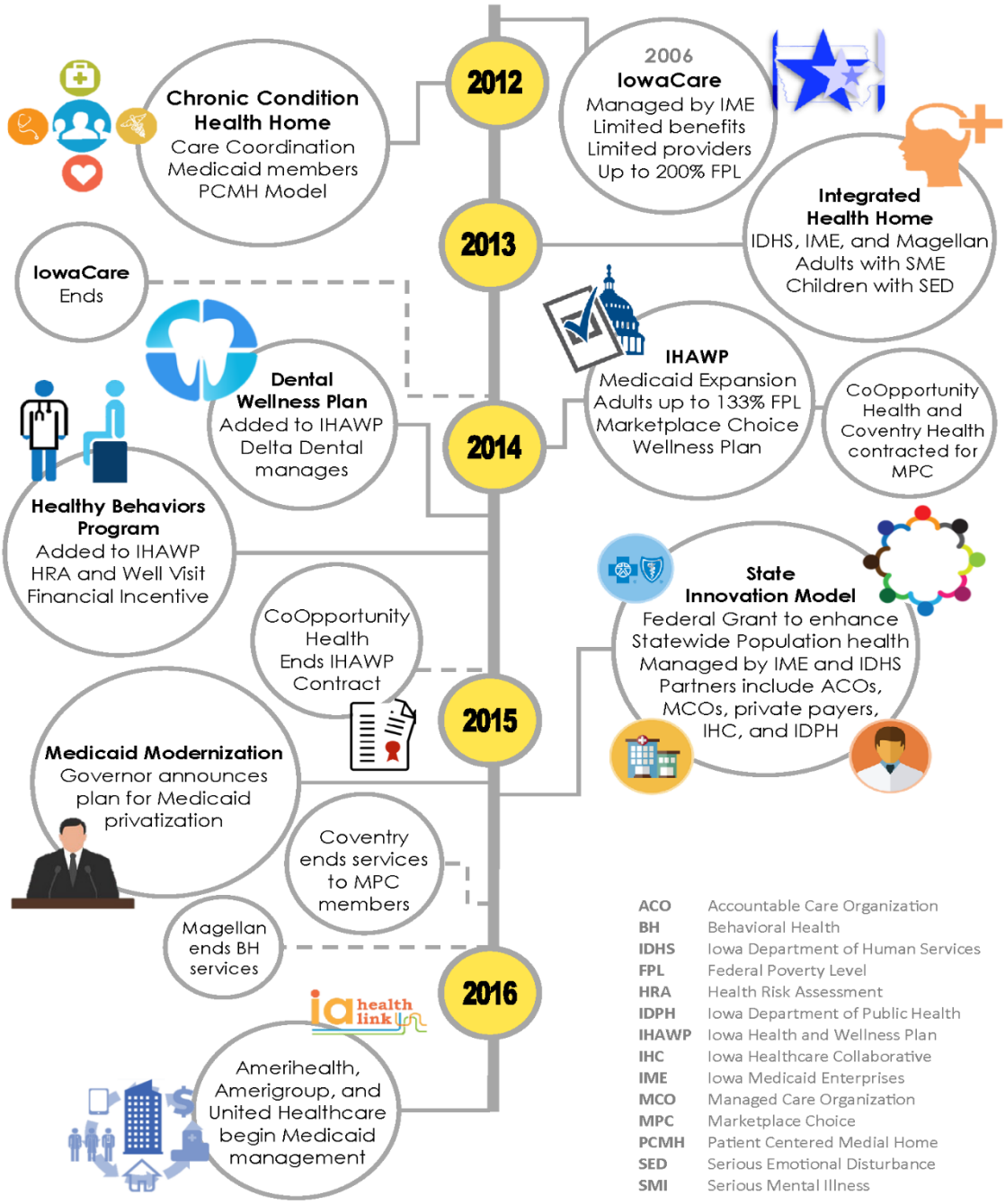
Table 1. IHAWP timeline

Date	Change
January 2014	First IHAWP members enrolled
May 2014	MPC members enrolled in Dental Wellness Plan with Delta Dental of Iowa
July 2014	MPC members enrolled in the Healthy Behaviors Incentive Program
November 2014	MPC members in CoOportunity transitioned to MediPASS (PCCM program), Meridian (HMO), or Coventry (QHP)
November 2015	MPC members in Coventry transitioned to MediPASS or Fee-for-service (MPC component dormant)
April 2016	MPC members transitioned to one of three MCOs - AmeriGroup Iowa, AmeriHealth Caritas, or UnitedHealthcare Plan of the River Valley
November 2017	AmeriHealth Caritas exists Medicaid program

Other activities in Iowa

Other activities occurring in Iowa's health care system during the implementation and first three years of IWP may have affected some of the outcomes in this report (**Figure 1**). For example, Iowa completed the first three years of a four-year State Innovation Model project implementing statewide system changes designed to increase the proportion of providers in value-based purchasing (VBP) contracts, increase members covered by VBP contracts, enhance health information technology (HIT) to provide alerts regarding emergency department use, and improve population health through targeted model projects and statewide health strategies. Along with the introduction of MCOs, these activities implemented statewide make it more difficult to isolate IWP-induced changes in utilization or health outcomes.

Figure 1. Iowa health system changes



Study populations

Within the IHAWP evaluation there are seven distinct groups. Two of these are the study groups, Wellness Plan and Marketplace Choice, as described above. There are five additional comparison groups used for various parts of the evaluation, where such a comparison is appropriate. Analyses involving administrative data utilize adult members in the Family Medical Assistance Program (FMAP) and adult members of IowaCare as comparisons. Analyses involving survey data utilize adult members of the Medicaid State Plan who were eligible due to income (MSP).

FMAP – Family Medical Assistance Program

The FMAP comparison group is composed of adult parents of children eligible for Medicaid. Non-employed and employed parents of children in Medicaid in families with incomes from 0-77% FPL are eligible for Medicaid coverage. As they earn more they are able to increase the percent FPL allowed for eligibility to encourage employment.

MSP – Medicaid State Plan

MSP consists of members enrolled due to FPL between 0 and 66%. There are approximately 300,000 adults who will have at least one month of data in the study period. MSP members enrolled due to disability determination are not included in these results.

IowaCare

IowaCare was a limited provider/limited benefit program that operated from 2005-2013. The provider network included one public hospital in Des Moines, the largest teaching hospital in the state, and 6 federally qualified health centers (FQHC). The plan served adults not otherwise eligible for Medicaid, with incomes up to 200% FPL. The Iowa Health and Wellness Plan replaced the IowaCare program, providing the opportunity to utilize previously collected and assimilated administrative and survey data (pre-implementation data) for enrollees from this program. IowaCare enrollees were distributed in three places following the elimination of this program.

People with incomes 0-100% FPL were enrolled in Wellness Plan
People with incomes 101-133% FPL were enrolled into Marketplace Choice
People whose income was from 134-200% or whose income could not be verified were not enrolled in any program

IowaCare did not provide coverage for routine dental coverage or prescription medications. In addition, primary care providers (Medical Homes) were limited to eight sites for outpatient care, six Federally Qualified Health Centers, the University of Iowa Hospitals and Clinics (UIHC), and Broadlawns Medical Center (BMC). Options for emergency or inpatient care were limited to UIHC and BMC.

The map below (**Figure 2**) shows the provider locations and counties in which IowaCare members were assigned to each Medical Home while in IowaCare. IHAWP only covers uninsured adults up to 133% FPL, but provides prescription drug coverage, dental care and a much broader provider network than was available for members in IowaCare. Members who were eligible for IHAWP and enrolled in the IowaCare program as of December 31, 2013 were automatically enrolled into IHAWP as of January 1, 2014 if they met the eligibility criteria. Since IowaCare provided coverage for adults up to 200% FPL and IHAWP provides coverage to only 133% FPL, IowaCare members with incomes between 134% and 200% FPL were not auto-enrolled into IHAWP.

Figure 2. Map of IowaCare Medical Home Regions

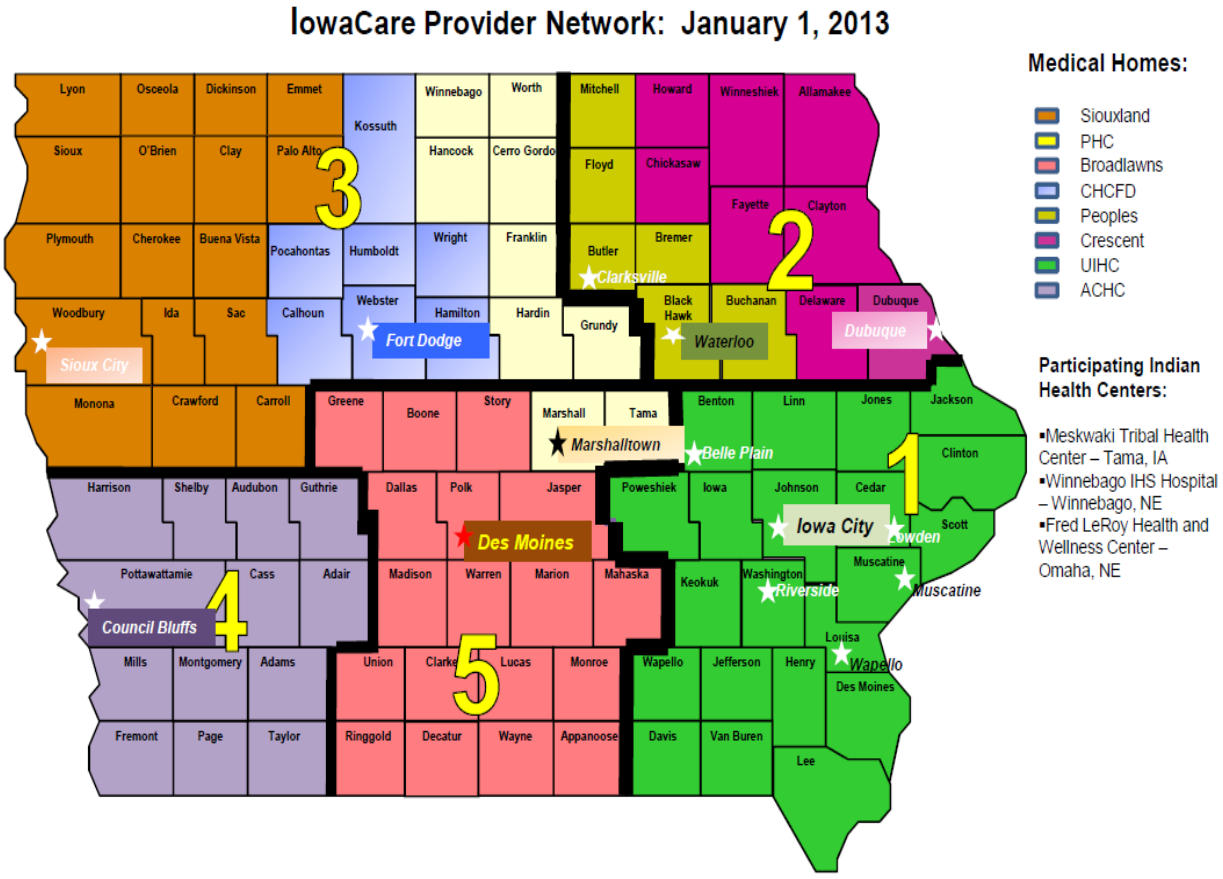


Table 2 provides comparisons of IWP members from CY 2014 – CY 2017. The characteristics of IWP members remained stable over the three years following implementation. IWP members were equally likely to be male or female and most likely to be white, between 22 and 30 years of age, and live in a metropolitan area.

Table 2. Demographic characteristics of IWP members CY 2014 - 2017

	CY 2017 N (%)	CY 2016 N (%)	CY 2015 N (%)	CY 2014 N (%)
Gender				
Female	117,991 (53%)	105,606 (51%)	102,598 (52%)	78,421 (51%)
Male	102,372 (47%)	99,413 (49%)	95,086 (48%)	74,966 (49%)
Race				
White	140,324 (64%)	134,327 (66%)	129,637 (66%)	99,487 (65%)
Black	18,844 (9%)	17,337 (9%)	15,932 (8%)	11,908 (8%)
American Indian	3,473 (2%)	3,145 (2%)	2,609 (1%)	2,017 (1%)
Asian	5,226 (2%)	4,687 (2%)	4,323 (2%)	3,066 (2%)
Hispanic	10,156 (5%)	9,182 (5%)	8,122 (4%)	5,548 (4%)
Pacific Islander	1,102 (<1%)	1,075 (<1%)	1,243 (1%)	819 (1%)
Multiple—Hispanic	2,904 (1%)	2,643 (1%)	2,330 (1%)	1,502 (1%)
Multiple—Other	2,188 (1%)	2,064 (1%)	1,810 (1%)	1,179 (1%)
Undeclared	36,146 (16%)	30,559 (15%)	31,678 (16%)	27,861 (18%)
Age				
18-21 years	18,205 (8%)	20,666 (10%)	19,325 (10%)	11,599 (8%)
22-30 years	62,203 (28%)	56,234 (27%)	53,039 (27%)	38,997 (25%)
31-40 years	53,260 (24%)	47,067 (23%)	44,720 (23%)	33,722 (22%)
41-50 years	38,780 (18%)	36,281 (18%)	35,588 (18%)	30,503 (20%)
51 and over	47,915 (22%)	44,769 (22%)	45,012 (23%)	38,566 (25%)
County rural/urban status				
Metropolitan	132,548 (60%)	121,398 (60%)	119,368 (60%)	93,551 (61%)
Non-metropolitan, urban	77,167 (35%)	69,809 (34%)	68,988 (35%)	52,977 (35%)
Non-metropolitan, rural	10,648 (5%)	9,705 (5%)	9,328 (5%)	6,859 (4%)
Total	**220,363**	**205,019**	**197,684**	**153,387**

Limitations to the study

For CY 2016 we provided a special note of caution in regard to comparisons over time. Though we provided some trend data, the change in data source and management may have led to variance in how claims were coded for billing and the quality of the data for analysis. However, results for CY 2017 were similar to the results for CY 2016, providing validation for the veracity of the CY 2016 results.

From CY 2016 forward we were able to include many more IWP members for measures requiring at least 11 months of eligibility for the measurement year and each of the two years prior to the measurement year (primarily breast cancer and cervical cancer screening). This is the second measurement year that members could have been eligible for IWP across three years. For example, the numbers of women receiving a breast cancer screening increased considerably from 1,855 to 4,430 though as a proportion of the eligible members the rate only increased from 60% to 62% in CY 2016.

As mentioned, the IowaCare program did not provide prescription drug coverage. This limits our ability to use the IowaCare data in measures that require data on medication use. In addition, members who were or became dually enrolled in Medicaid and Medicare are removed from the analysis, since accurate claims data were not available.

Previous results

Reports containing previous analyses and results can be found at

- IHAWP evaluation - http://ppc.uiowa.edu/health/study/evaluation-iowas-medicaid-expansion-iowa-health-and-wellness-plan
- Healthy Behavior Program - http://ppc.uiowa.edu/publications/healthy-behaviors-incentive-program-evaluation
- Provider network adequacy - http://ppc.uiowa.edu/publications/evaluation-provider-adequacy-iowa-health-and-wellness-plan-during-first-year

Methodology

Data Availability and Primary Collection

Data Access

The Public Policy Center (PPC) has worked closely with the State of Iowa to ensure that the assurances needed to obtain data are firmly in place. The PPC has a data sharing Memorandum of Understanding (MOU) with the State of Iowa to utilize Medicaid claims, enrollment, encounter, and provider data for approved research activities. All research activities must be approved by the University of Iowa Institutional Review Board (IRB) and the Iowa Department of Human Services. Additional data agreements will be initiated as needed, though at present none are anticipated.

Data sources

Administrative data

This evaluation provides a unique opportunity to optimize several sources of data to assess the effects of innovative coverage options. The PPC is home to a Medicaid Data Repository encompassing over 100 million claims, encounter and eligibility records for all Iowa Medicaid enrollees for the period January 2000 through the present. Data are assimilated into the repository on a monthly basis. Ninety-five percent of medical and pharmaceutical claims are completely adjudicated within three months of the first date of service, while the 'run out' for institutional claims is six months. The PPC staff has extensive experience with these files as well as extensive experience with CMS adult core measures and Healthcare Effectiveness Data and Information Set (HEDIS) measures. In addition, the database allows members to be followed for long periods of time over both consecutive enrollment months and periods before and after gaps in coverage. When the enrollment database was started in 1965, Iowa made a commitment to retain member identification numbers for at least three years and to never reuse the same Medicaid ID number. This allows long-term linkage of member information including enrollment, cost, and utilization throughout changes in programs.

The evaluation strategy outlined here is designed to maximize the use of outcome measures derived through administrative data manipulation using nationally recognized protocols from the National Quality Forum (NQF) and National Committee on Quality Assurance (NCQA) HEDIS.

Member surveys

This report includes data from surveys of Wellness Plan (WP), Marketplace Choice Plan (MPC), and Medicaid State Plan (MSP). Surveys with members of the WP, MPC, and MSP, were fielded post-implementation of the IHAWP (in October of 2014 and are included to provide results for hypotheses that were no longer deemed critical during the most recent waiver period. Surveys fielded in spring 2017 provided most of the information utilized to evaluate hypotheses. Detailed survey methodology, including the survey instruments, responses to each item in the surveys, and summarized results can be found at the Public Policy Center website.

Analytic methods

A statistical means test between WP/MPC (IHAWP) and IowaCare members (pre-IHAWP) was not conducted because two of the ways these populations differ cannot be adequately accounted for in the analytics. First, there are many fundamental differences in coverage between the former IowaCare program and the IHAWP which make direct comparisons on many of the survey outcomes irrelevant. Second, an assumption that the majority of the sample and respondents to the IHAWP survey would be people who were previously in the IowaCare program was

unfounded. Upon analysis, the majority of the respondents to the IHAWP (over 60%) had never been in the IowaCare program which made the intended pre-post comparison less relevant. However, if available, data from the IowaCare 2012 survey is presented for reference.

For all survey analyses presented, the data was weighted to make it representative of all IHAWP and Medicaid members statewide and to account for the fact that there were not equal numbers of enrolled members in each sampled group. Thus, the percentages reported were weighted to reflect the statewide membership in each group. For the inferential statistics, the weight variable was re-based to the actual sample size in order to ensure that, while the adjustments for sampling method were retained, the standard errors used in the statistical testing were not artificially inflated.

Some limitations are inherent to survey research and some were the result of programmatic changes that may affect the interpretation of the results. First, those who chose to respond to the survey may be different from those who chose not to respond which can create biased results. In this evaluation, respondents (both to the Medicaid and the IHAWP surveys) were more likely to be female, white, and older than those who did not respond to the surveys. Second, respondents may have difficulty accurately remembering events which may introduce recall bias. This risk may not be high because of the relatively short time period for recalling events (6 months). Third, there were plan and programmatic changes that occurred during the fielding of these surveys that could have influenced the responses. One of the MPC plans (CoOp) exited the MPC around the time of the administration of this survey and that may have affected the experiences of those members differently than the members of the other MPC plan, Coventry Health as well as the members of the WP and MSP groups.

Results

The results below are presented in a similar order to what was in the original evaluation plan to allow the reader to more easily see the progress on each hypothesis and measure. There are some measures which, after a more thorough assessment of the available data, are no longer appropriate and this is indicated with the measure.

Access to Care

Question 1 *What are the effects of the Iowa Wellness Plan on member access to care?*

Hypothesis 1.1

Iowa Wellness Plan members will have equal or greater access to primary care and specialty services.

Measure 1 Access to primary care

Percent of members who had an ambulatory care visit

Definition

This measure protocol derives from HEDIS 2018. It provides the proportion of adults 20-64 years of age that were eligible for at least 11 months during the measurement year and 11 months during the year prior to the measurement year that had at least 1 preventive or ambulatory care visit during the measurement year.

Results

Table 3 indicates that FMAP adults were more likely to have a preventive/ambulatory visit throughout the study period, however, the proportion of IWP adults with a visit increased over this time. For adults 20-44 years of age in CY 2017, the proportion of FMAP adults with a visit was 89%, down 1% from CY 2016 but still above CY 2015 levels. During this same time, the proportion of IWP adults with a visit was 84%, down 2% from CY 2015 but up 8% from CY 2014. For adults 45-64 years of age, the proportion of FMAP adults with a visit dropped from 90% to 89%, while the proportion of IWP adults remained stable at 90% during that same time. In CY 2016, IWP adults 45-64 were as likely to have had a visit as the FMAP group. (See Figure 3 and Figure 4).

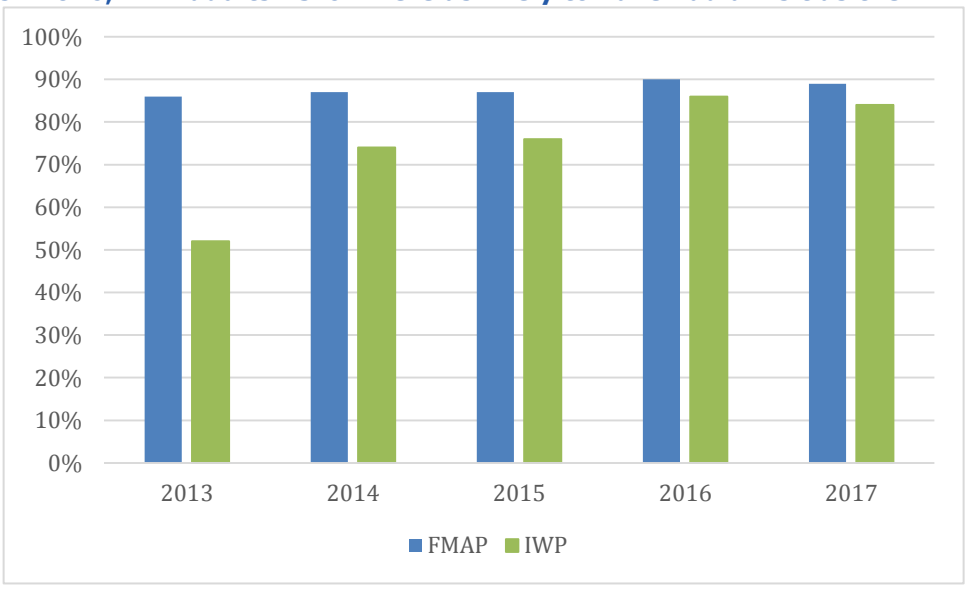


Table 3. Adults' access to preventive/ambulatory health services by program and age CY 2013 – CY 2017

Age	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
20-44 yrs	14,706	8,876	16,556	16,633	17,065	27,629	14,624	27,339	14,961	32,926
	86%	52%	87%	74%	87%	76%	90%	86%	89%	84%
45-64 yrs	1,494	9,016	2,049	14,428	2,386	20,287	2,309	23,832	2,323	25,238
	85%	66%	86%	83%	88%	84%	90%	90%	89%	90%
Total	16,200	17,892	18,606	31,061	19,451	47,916	16,933	51,271	17,329	58,474
	86%	59%	87%	78%	87%	79%	90%	88%	89%	86%

Figure 3. Access to preventive/ambulatory health services for adults 20-44 years of age by program and year, CY 2013-CY 2017

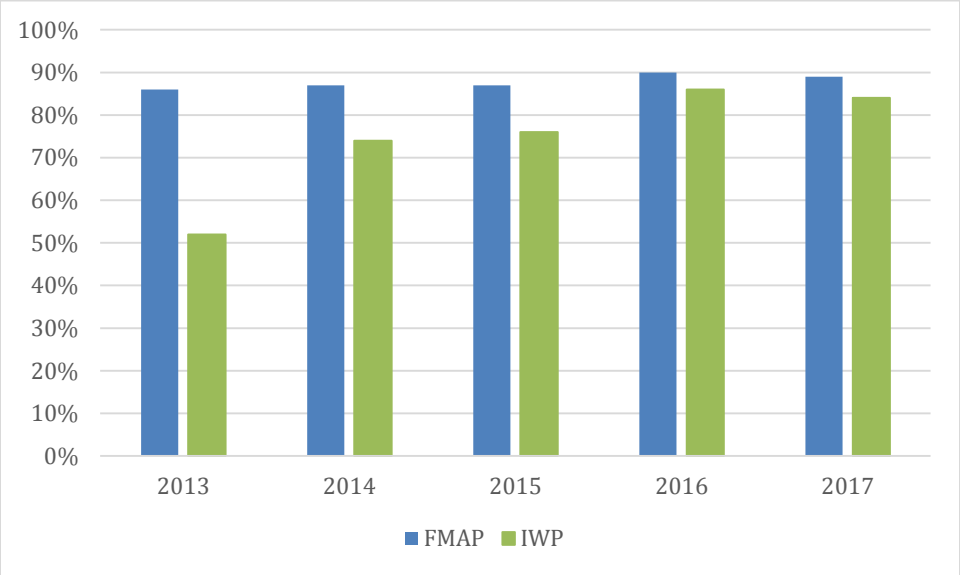
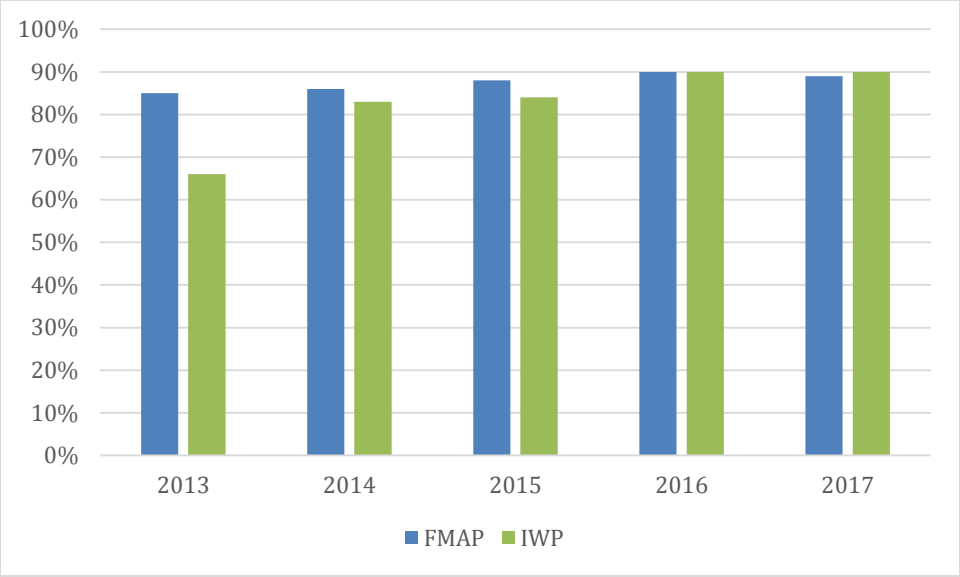


Figure 4. Access to preventive/ambulatory health services for adults 45-64 years of age by program and year, CY 2013-CY 2017



Whether a member had an ambulatory or preventive care visit

The DID framework is combined with multiple modeling frameworks to assess the robustness of the parameter estimation. Normal and logistic generalized estimating equation (GEE) models which account for within-individual correlation are fit. Additionally, a normal regression with individual random effects, a conditional logistic regression matching on individual is fit to further assess robustness. Equation (1) below expresses the normal GEE DID model and equation (2) the logistic GEE DID model:

$$Y_{it} = \mu + \gamma_{\text{FMAP}} + \gamma_{\text{SSI}} + \gamma_{\text{WP}} + \gamma_{\text{MPC}} + \text{T}_\text{t} + \gamma\text{T}_{\text{MPC}*\text{post}} + \gamma\text{T}_{\text{Wp}*\text{post}} + \mathbf{X}'_{\text{it}}\boldsymbol{\beta} + \varepsilon_{it} \qquad (1)$$

$$logit(Y_{it}) = \mu + \gamma_{\text{FMAP}} + \gamma_{\text{SSI}} + \gamma_{\text{WP}} + \gamma_{\text{MPC}} + \text{T}_\text{t} + \gamma\text{T}_{\text{MPC}*\text{post}} + \gamma\text{T}_{\text{WP}*\text{post}} + \mathbf{X}'_{\text{it}}\boldsymbol{\beta} \qquad (2)$$

where Y_{it} is an indicator for member *i* receiving a wellness visit in time period *t*, the γ terms are the program effects, T_t indicates the time period, $\gamma\text{T}_{\text{MPC}*\text{post}}$ is the MPC specific DID estimate, $\gamma\text{T}_{\text{WP}*\text{post}}$ the WP specific DID estimate, $\mathbf{X}'_{\text{it}}\boldsymbol{\beta}$ captures all other predictors controlled for, and ε_{it} the random error. The additional predictors controlled for include sex, race, UIC, age indicators, FPL indicators, months in a MHH indicators, months in a IHH indicators, had delivery, and chronic illnesses. Variations of all models were fit using only a subset of additional predictors, excluding having a delivery and chronic illnesses. Additionally, variations of all models are fit with the DID estimate for MPC and WP pooled into a single DID estimate; this is achieved by replacing $\gamma\text{T}_{\text{MPC}*\text{post}} + \gamma\text{T}_{\text{Wp}*\text{post}}$ with $\gamma\text{T}_{(\text{MPC or WP})*\text{post}}$ in equations (1) and (2).

Due to the nature of the models the GEE approach can estimate effects that are unchanging over time, such as sex and chronic illness status. Both the normal regression with individual random effects and conditional logistic regression matching on individual cannot estimate these. The robustness check solely focused on the DID parameter estimation.

Four different types of Models were fit as a robustness check.

1. Linear: OLS with person effects and robust standard errors
2. Linear: Generalized Estimating Equations (GEE)
3. Logistic: Conditional logistic regression with robust standard errors
4. Logistic: Generalized Estimating Equations (GEE)

Each model was fit using the full set and a reduced set of predictors.

1. Subset of predictors: sex, race, UIC, age, FPL, MHH, IHH, program, post indicator, DID estimates
2. All predictors: Subset of predictors + pregnancy, illness indicators

Each combination of the 4 model types and 2 sets of predictors were first fit with a separate DID estimator for WP/MPC and then fit with a pooled DID estimator for WP/MPC.

Results

Regardless of the model, DID estimator(s) always indicated that the likelihood of getting a wellness visit increased for those in WP or MPC over time, with a larger increase for WP than MPC (**Figure 5**). Regardless of model type and predictors used regression estimates are nearly identical across linear models and very similar across logistic models (**Table 4** and **Table 5**).

Figure 5. Proportion of members with a well adult visit by program

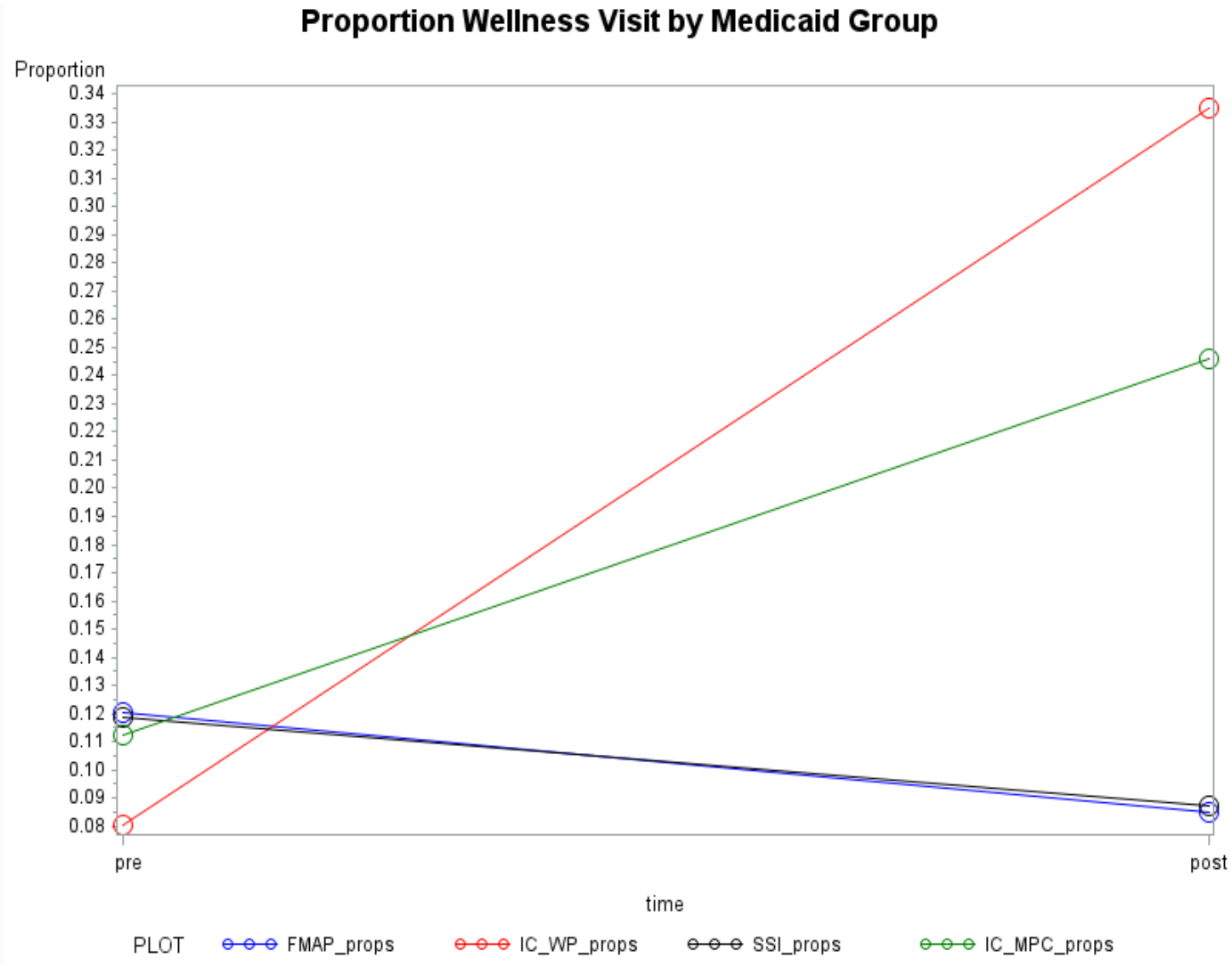


Table 4. Regression estimates for the full model across all model types

Response	Linear	Linear	Linear	Linear	Logistic	Logistic	Logistic	Logistic
Predictors	Subset	Subset	All	All	Subset	Subset	All	All
DID Estimate	Separated	Pooled	Separated	Pooled	Separated	Pooled	Separated	Pooled
Parameter	Beta	Beta	Beta	Beta	Beta	Beta	Beta	Beta
Intercept	0.0544***	0.0554***	0.0176***	0.0186***	-2.5889***	-2.5807***	-2.9796***	-2.9704***
Had delivery	-	-	-0.0465***	-0.0467***	-	-	-0.5487***	-0.5508***
Chronic Illnesses								
Attention Deficit Disorder	-	-	0.0115	0.0115	-	-	0.1168*	0.1172*
Acute Myocardial Infarction	-	-	-0.0329**	-0.0329**	-	-	-0.3203**	-0.3217**
Anxiety	-	-	-0.0049	-0.0049	-	-	-0.0352	-0.0358
Asthma	-	-	-0.0007	-0.0007	-	-	0.0025	0.0024
Coronary Artery Disease	-	-	-0.0079*	-0.0079*	-	-	-0.0622	-0.0618
COPD Emphysema	-	-	-0.0148***	-0.0149***	-	-	-0.1188**	-0.1192**
Cerebrovascular Event	-	-	-0.0146*	-0.0145*	-	-	-0.1209*	-0.1203*
Developmental Disorder	-	-	0.0485**	0.0483*	-	-	0.4053**	0.404**
Dementia	-	-	-0.0358	-0.0358	-	-	-0.3706	-0.3695
Depression	-	-	-0.0036	-0.0036	-	-	-0.0341	-0.0339
Diabetes	-	-	-0.0344***	-0.0344***	-	-	-0.2754***	-0.275***
Hypertension	-	-	0.0031	0.0031	-	-	0.0287	0.0291
Hypercholesterolemia	-	-	0.0499***	0.0499***	-	-	0.4032***	0.4021***
Liver Disease	-	-	-0.0022	-0.0022	-	-	-0.0145	-0.0155
Mental Health Problem	-	-	0.0332***	0.0332***	-	-	0.2979***	0.2975***
Mood Disorder	-	-	-0.0023	-0.0024	-	-	-0.0061	-0.0054
Mental Retardation	-	-	0.1100***	0.1101***	-	-	0.8398***	0.8405***
Obseity	-	-	0.0337***	0.0337***	-	-	0.2853***	0.2847***
Parkinson's MS	-	-	0.0086	0.0087	-	-	0.0870	0.0877
Pervasive Developmental Disorder	-	-	0.087***	0.087***	-	-	0.7075***	0.7058***
Pervsistent Mental Health Disorder	-	-	-0.0074	-0.0074	-	-	-0.0644	-0.0662
Renal Failure	-	-	-0.0234***	-0.0233***	-	-	-0.2141***	-0.214***
Substance Abuse Problem	-	-	-0.0018	-0.0019	-	-	-0.0113	-0.0122
Schizophrenia	-	-	0.0585***	0.0585***	-	-	0.5209***	0.5204***
FPL								
FPL equal 0	-	-	-	-	-	-	-	-
FPL between 1-37	0.0227***	0.0224***	0.0221***	0.0218***	0.1739	0.1712	0.1698***	0.1671***
FPL between 38-75	0.0187***	0.0177***	0.0165***	0.0156***	0.1547	0.1479	0.1399***	0.1331***
FPL between 76-100	0.0265***	0.0246***	0.026***	0.0242***	0.2112	0.1984	0.2115***	0.1988***
FPL between 101-133	0.0268***	0.0147*	0.0269***	0.0149*	0.2141	0.1428	0.2148***	0.1427**
FPL greater than 134	0.0208*	0.0204*	0.0200*	0.0197*	0.1820	0.1803	0.1793**	0.1776*
Female Indicator	0.047***	0.0472***	0.0429***	0.0431***	0.3967	0.3968	0.3672***	0.3673***
In an IHH ≥ 6 months	0.0549***	0.055***	0.0274***	0.0274***	0.4866	0.4870	0.2537***	0.2541***
In an MHH ≥ 6 months	-0.0213***	-0.0213***	-0.0372***	-0.0372***	-0.2198	-0.2200	-0.3639***	-0.3638***
UIC	0.0182***	0.0183***	0.0212***	0.0212***	0.1753	0.1754	0.2012***	0.2012***
Time period (Post)	-0.0337***	-0.0336***	-0.0348***	-0.0348***	-0.3715	-0.3714	-0.3897***	-0.3897***
Age Indicators								
Age between 19-21	0.0073	0.0074	0.0158**	0.0159**	0.0581	0.0586	0.1388*	0.1391*
Age between 22-30	-0.0136***	-0.0135***	-0.006*	-0.0059	-0.1372	-0.1357	-0.0667*	-0.0653*
Age between 31-44	-	-	-	-	-	-	-	-
Age between 45-64	0.0183***	0.0182***	0.0179***	0.0178***	0.1587	0.1575	0.1517***	0.1505***
Race								
American Indian	-0.0162	-0.0165	-0.0101	-0.0104	-0.1583	-0.1592	-0.1099	-0.1111
Asian	0.0403***	0.0406***	0.0542***	0.0544***	0.2928	0.2928	0.4322***	0.4321***
Black	0.0014	0.0011	0.0095*	0.0093*	0.0131	0.0119	0.0810*	0.0796*
Hispanic	0.0047	0.0048	0.0058	0.0059	0.0394	0.0397	0.0518	0.0521
Multiple-Hispanic	-0.0126	-0.0125	-0.0117	-0.0116	-0.1134	-0.1113	-0.1058	-0.1038
Multiple-other	0.0106	0.0108	0.0169	0.0170	0.1103	0.1136	0.1752	0.1785
Pacific Islander	-0.0031	-0.0027	0.0000	0.0004	-0.0167	-0.0220	0.0181	0.0140
Unknown	0.0214***	0.0209***	0.0235***	0.023***	0.1750	0.1710	0.1956***	0.1916***
White	-	-	-	-	-	-	-	-
Program Indicators								
FMAP	0.0008	0.0001	0.0175***	0.0168***	0.0369	0.0322	0.2231***	0.2182***
SSI	-	-	-	-	-	-	-	-
IC -> MPC	-0.0091**	-0.0596***	0.0018	-0.0487***	-0.0751	-0.5877	0.0537	-0.4615***
IC -> WP	-0.0331***	-0.0229***	-0.0218***	-0.0116***	-0.3847	-0.2755	-0.2563***	-0.147***
DID Estimates								
MPC DID Estimator	0.156***	-	0.1576***	-	1.2362***	-	1.2689***	-
WP DID Estimator	0.2815***	-	0.283***	-	2.0869***	-	2.1302***	-
MPC/WP DID Estimator	-	0.2609***	-	0.2625***	-	1.9457***	-	1.9872***

Table 5. Regression estimates for the reduced model across all model types

Response	Linear	Linear	Linear	Linear	Logistic	Logistic	Logistic	Logistic
Predictors	Separated	Separated	Pooled	Pooled	Separated	Separated	Pooled	Pooled
DID Estimate	Subset	All	Subset	All	Subset	All	Subset	All
Parameter	Beta	Beta	Beta	Beta	Beta	Beta	Beta	Beta
Intercept	0.1206***	0.1223***	0.1253***	0.1269***	-	-	-	-
Had delivery	-	-0.0421***	-	-0.0424***	-	-0.5465***	-	-0.5480***
UIC	-0.0323*	-0.0330*	-0.0319*	-0.0319*	-0.1937	-0.1856	-0.1826	-0.1745
Age Indicators								
Age between 19-21	-0.0379	-0.0368	-0.0386	-0.0374	-0.4076**	-0.3656**	-0.4017**	-0.3595**
Age between 22-30	-0.0259	-0.0251	-0.0254	-0.0245	-0.2831*	-0.2635	-0.2775*	-0.2580
Age between 31-44	-	-	-	-	-	-	-	-
Age between 45-64	-0.0090	-0.0084	-0.0071	-0.0066	-0.0984	-0.0965	-0.1008	-0.0990
FPL Indicators								
FPL equal to zero	-	-	-	-	-	-	-	-
FPL between 1-37	0.0346***	0.0346***	0.0323***	0.0323***	0.1648**	0.1630**	0.1475*	0.1460*
FPL between 38-75	0.024*	0.0246*	0.0176	0.0173	0.0796	0.0723	0.0192	0.0119
FPL between 76-100	0.0344*	0.0343*	0.0138	0.0137	0.1249	0.1251	-0.0488	-0.0491
FPL between 101-133	0.0234	0.0231	-0.0300	-0.0302	0.0997	0.0989	-0.3442*	-0.3457*
FPL ≥ 134	0.0081	0.0076	-0.0183	-0.0188	0.1203	0.1182	-0.0822	-0.0849
In a MHH ≥ 6 months	0.0202	0.0200	0.0202	0.0200	0.1318	0.1312	0.1299	0.1294
In a IHH ≥ 6 months	-0.0006	-0.0004	-0.0007	-0.0005	0.0136	0.0167	0.0159	0.0191
Time Period (Post)	-0.0342***	-0.0357***	-0.0343***	-0.0358***	-0.4641***	-0.4844***	-0.4643***	-0.4848***
DID Estimates								
WP DID Estimator	0.2803***	0.2817***	-	-	2.3793***	2.4004***	-	-
MPC DID Estimator	0.1555***	0.1570***	-	-	1.4589***	1.4806***	-	-
MPC/WP DID Estimator	-	-	0.2615***	0.2629***	-	-	2.2312***	2.2524***

Measure 2 Follow-up after hospitalization for mental illness (Measures 2A and 2B)

Percent of discharges for members with a mental illness diagnosis that were followed by a visit with a mental health provider

Whether a member discharged with a mental illness diagnosis had a follow-up visit with a mental health provider

Measure 2 has been removed from the evaluation due to extremely small numbers. Across the four comparison groups we were able to identify 198 hospitalizations for mental illness over the 3 years 2013-2015. These results may be due to most members with mental illness severe enough to warrant hospitalization being moved into the medical frail group or the existing Integrated Health Home program, both of which remove them from our analyses as these programs provide additional access for members with mental illness.

Measure 3 Access to and unmet need for urgent care

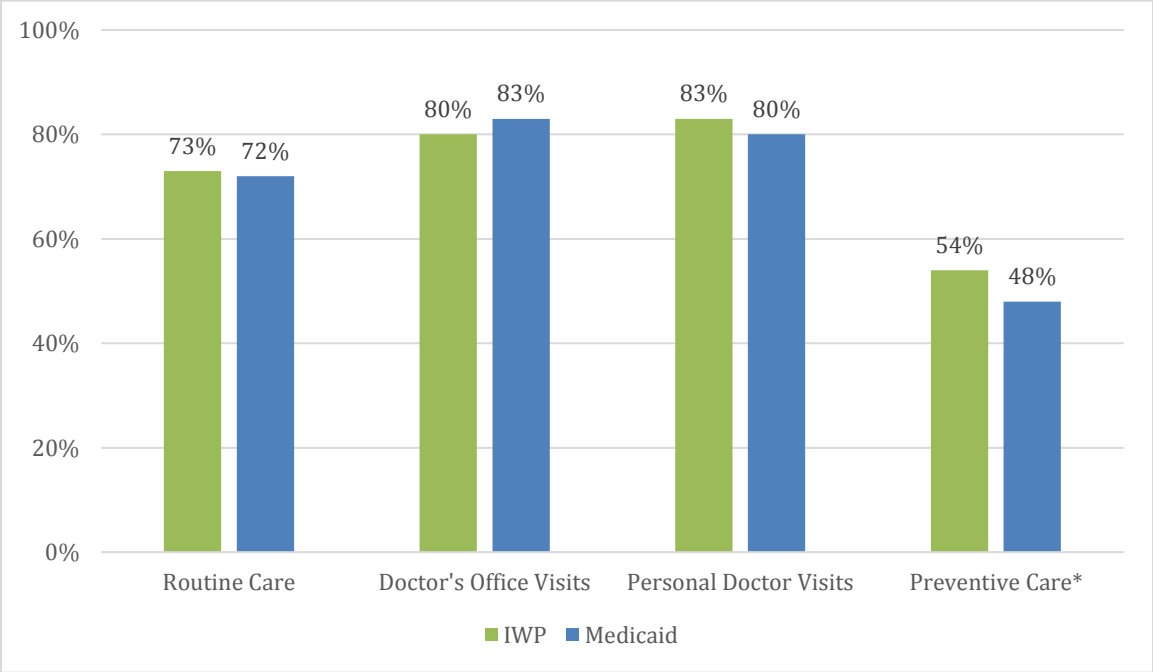
See results under Measure 7 Specialty Care.

Measure 4 Access to and unmet need for routine care

Primary care related services included making an appointment for a check-up or routine care, making any visit to a doctor's office or clinic to get health care, making any visits to their personal doctor (if they identified having one), and getting preventive care (such as a check-up, physical exam, mammogram, or Pap smear test).

Figure 6 shows the results of the comparison of primary care service utilization between IWP and Medicaid members. The majority of both IWP and Medicaid members reported using routine primary care services in the previous six months (73% routine care, 80% doctor's office visit, and 83% personal doctor visit). Significantly more IWP members (54%) reported having preventive care compared to Medicaid members (48%), p<.05.

Figure 6. Primary Care-Related Services Used by IWP vs Medicaid Members



* Statistically significant difference at p<.05

Note: Only members who reported having a personal doctor (n=1,367 IWP and n=680 Medicaid members) were asked about visits to their personal doctor.

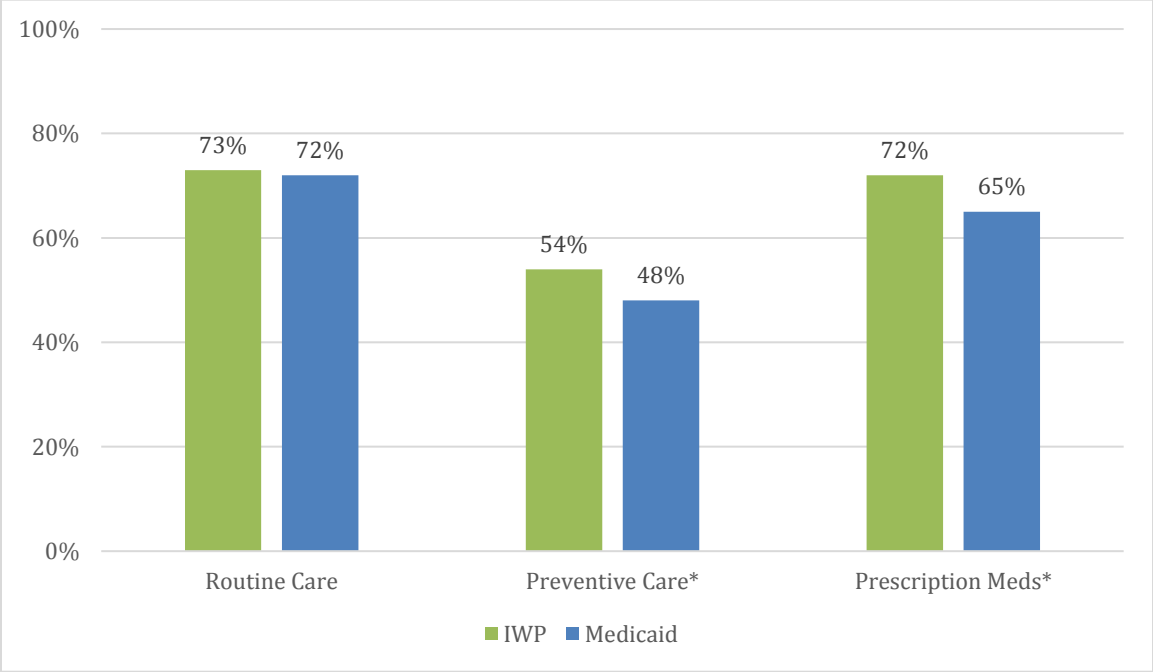
Need for primary care services was assessed by asking if respondents:

- made any appointments for a check-up or routine care
- got any preventive care
- thought (or a health professional thought) there was a time when they needed prescription medicine for any reason.

Figure 7 provides the need for primary care services for IWP and Medicaid members. A little over 70% of members reported a need for routine care with no difference between IWP and Medicaid. Significantly more IWP members (54%) compared to Medicaid members (48%) were able to receive preventive care. And, significantly more IWP members (72%) reported needing prescription medicine compared to Medicaid members (65%). At the same time, significantly more IWP members with a need for prescription medicine (89%) reported usually or always finding it

easy to get prescription medicine through their health plan when compared to Medicaid members with a need (84%).

Figure 7. Need for Primary Care-Related Services (IWP vs Medicaid)



* Statistically significant difference at p<.05

The survey included the following questions about unmet need for primary care services in the six months prior to the survey:

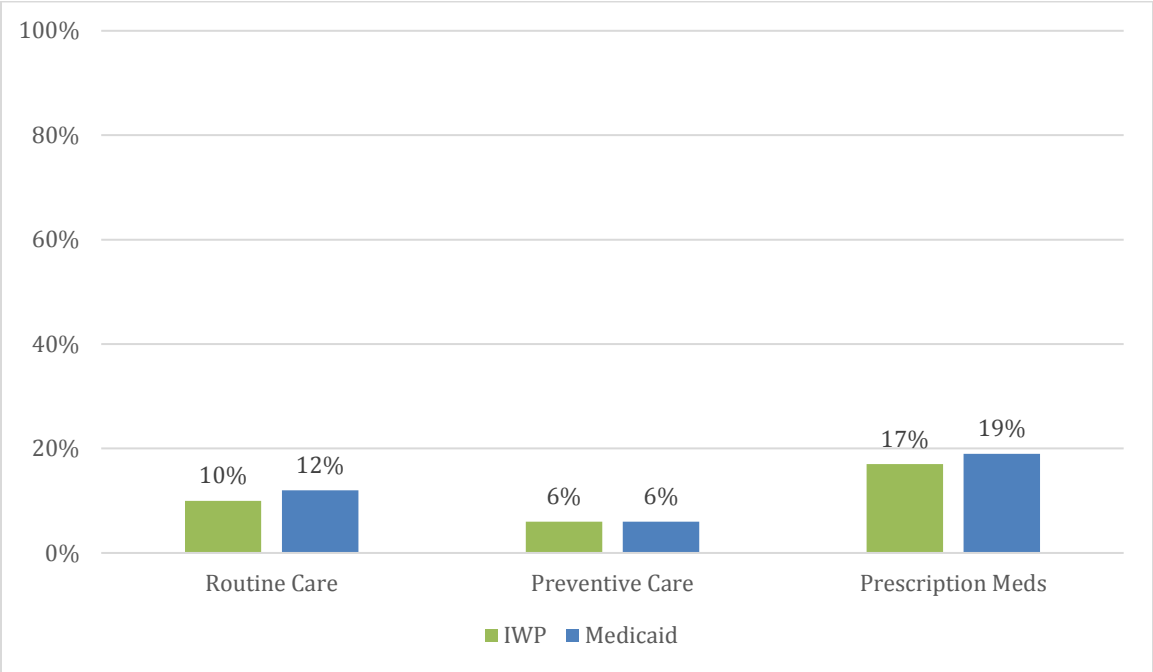
Was there any time when you needed a check-up or routine care but could not get it for any reason?

Was there any time when you needed preventive care but could not get it for any reason?

Was there any time when you needed prescription medicine but could not get it for any reason?

Figure 8 provides a comparison of IWP and Medicaid with regard to unmet need for primary care services. Overall, around 11% reported an unmet need for routine care and 6% an unmet need for preventive care with no statistically significant differences between IWP and Medicaid members. Almost one in five members (IWP 17%, Medicaid 19%) reported an unmet need for prescription medicine.

Figure 8. Unmet Need for Primary Care-Related Services (IWP vs Medicaid)



Measure 5 Timely Appointments, Care, and Information

The Patient-Centered Medical Home (PCMH) is a model of healthcare delivery that focuses on the core functions of primary care that should promote high quality in the provision of health care services.[2] In this evaluation, we focus on several aspects of the PCMH that are attributes of quality primary care. The attributes assessed were organized around three patient experiences with primary care: 1) identification of and continuity with a personal doctor, 2) experiences with the doctor's office [timely access to care and care coordination], and 3) experiences during office/provider visits [communication, comprehensive care, and self-management support]. These attributes are outlined below with full descriptions provided within each section.

1. Personal Doctor
    - Identification Of
    - Continuity With
2. Experiences with the Doctor's Office
    - Access to Care: Timely Access to Care
    - Access to Care: After-Hours Care
    - Care Coordination: Follow Up with Results of Testing
    - Care Coordination: Informed about Care with Specialists

[2] AHRQ. Patient-Centered Medical Home Resource Center. Available at http://pcmh.ahrq.gov/

- Care Coordination: Provider Knowledge of Patient Medical History
- Care Coordination: Provider Talked with Patient about Medications

3. Experiences During Office Visits
    - Communication with Personal Doctor
    - Comprehensive Care: Provider Talked with Patient about Stresses
    - Comprehensive Care: Preventive Care – Receipt of Flu Shot
    - Comprehensive Care: Smoking Cessation
    - Self-Management Support

Personal Doctor

All respondents were asked "Do you have a personal doctor [A personal doctor is the person you would see if you need a check-up, want advice about a health problem, or get sick or hurt.]?" 82% of IWP and 80% of Medicaid members had a personal doctor. There were no significant differences by MCO for IWP members.

For those with a personal doctor, members were asked "Is your personal doctor the same person who was your personal doctor before you enrolled in your MCO?" Response options included: Yes, I have the same personal doctor, No, I have a different personal doctor, and I did not have a personal doctor before enrolling in my MCO. Continuity with a personal doctor was defined as having had the same personal doctor before and after enrollment in their MCO. Significantly fewer IWP members (58%) than Medicaid members (64%) reported continuity with the same personal doctor ($p < .05$). Around 20% of IWP members had a different personal doctor after enrolling in their MCO compared to 16% of Medicaid members. And, around 20% (23% IWP, 20% Medicaid) of members reported not having a personal doctor before enrolling in their MCO. Again, for those in IWP, there were no significant differences by MCO with regard to personal doctor continuity.

Experiences with the doctor's office

To assess timely access to care, we used a three-item composite measure comprised of the following questions:

- When you needed care right away, how often did you get care as soon as you needed?
- How often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
- When you phoned a doctor's office during regular office hours, how often did you get an answer to your medical question that same day?

Access to after-hours care was assessed using one item that asked about whether or not the provider gave them information about how to access care after hours:

- Did a doctor's office give you information about what to do if you needed care during evenings, weekends, or holidays?

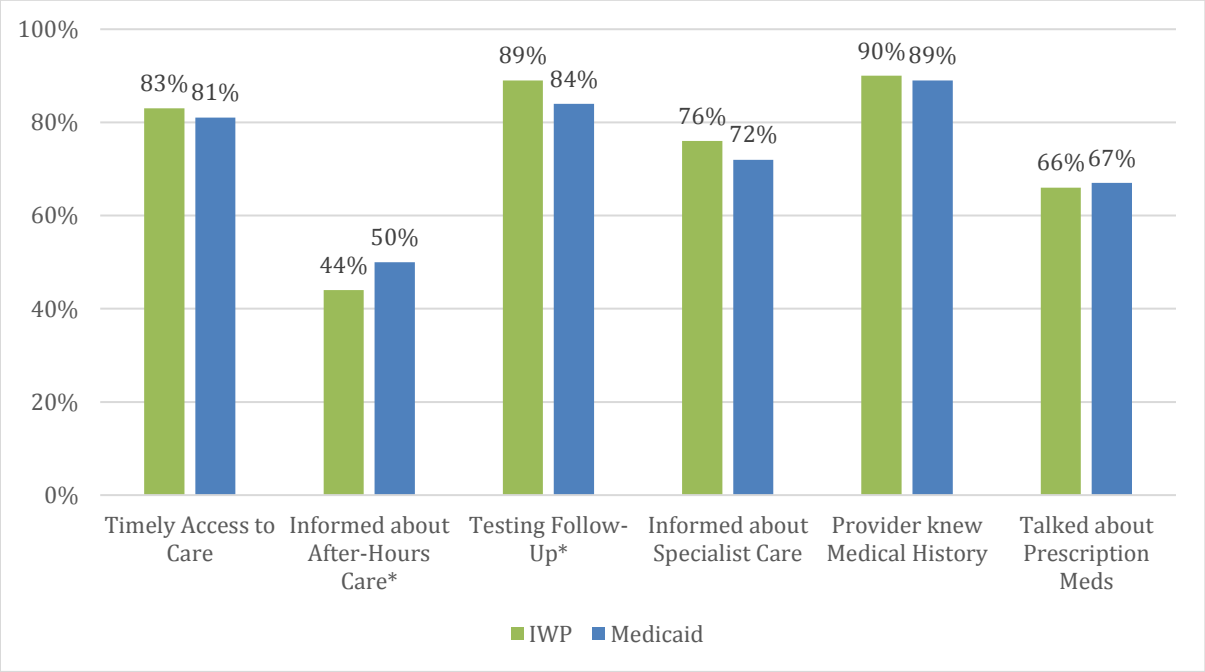
Care Coordination was assessed using four items related to different aspects of providing care coordination:

- When your doctor's office ordered a blood test, x-ray, or other test for you, how often did someone from the doctor's office follow up to give you those results?

- How often did your personal doctor's office seem informed and up-to-date about the care you got from specialists?
- How often did your personal doctor seem to know the important information about your medical history?
- How often did you talk with someone from your doctor's office about all the prescription medicines you were taking?

Figure 9 provides a summary of the findings with regard to members' experiences with their doctor's office. IWP and Medicaid members' experiences were similar with regard to timely access to care (83% IWP, 81% Medicaid), having a provider informed about specialist care (76% IWP, 72% Medicaid), having a provider who knew their medical history (IWP 90%, Medicaid 89%), and having talked about their prescription medicines (IWP 66%, Medicaid 67%). Yet, significantly more IWP members (89%) than Medicaid members (84%) reported that their doctor's office followed up with them to give them results of testing. And, around 50% of Medicaid members reported receiving information from their doctor's office about what to do if they needed care after-hours which was significantly higher than reported by IWP members (44%). Within IWP, there were no significant differences by MCO with regard to member experiences with their doctor's office.

Figure 9. IWP and Medicaid Member Experiences with their Doctor's Office



* Statistically significant difference at p<.05

Measure 6 After-hours care

See results under Measure 5 Timely Appointments, Care, and Information

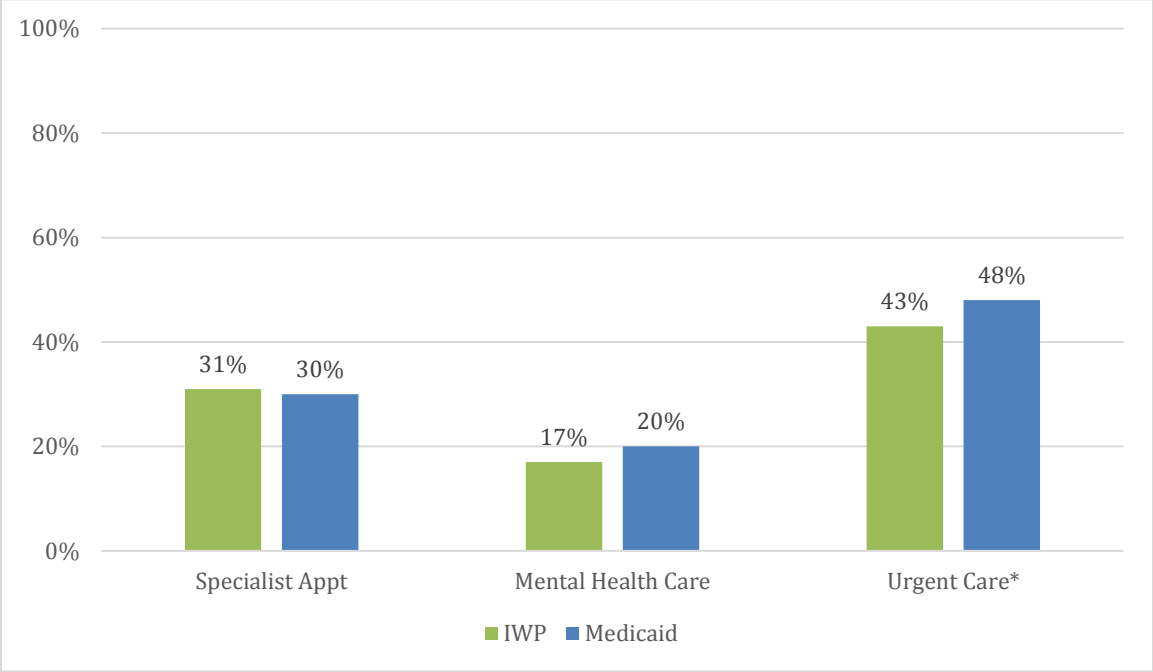
Measure 7 Specialist care

Specialty service use in the six months prior to the survey included any appointments with a specialist (defined as doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health

care), treatment or counseling for a mental or emotional health problem, and urgent care (defined as an illness, injury, or condition that needed care right away).

Figure 10 provides the results of the comparison of specialty service utilization between IWP and Medicaid members. Around one-third of IWP and Medicaid members (31% IWP, 30% Medicaid) made an appointment to see a specialist within the previous six months. And, around one in five (17% IWP, 20% Medicaid) reported receiving treatment or counseling for a mental or emotional health problem with no significant difference between IWP and Medicaid members. And, IWP members reported less need for urgent care (43%) when compared to Medicaid members (48%).

Figure 10. Specialty Care-Related Services Used by IWP vs Medicaid Members



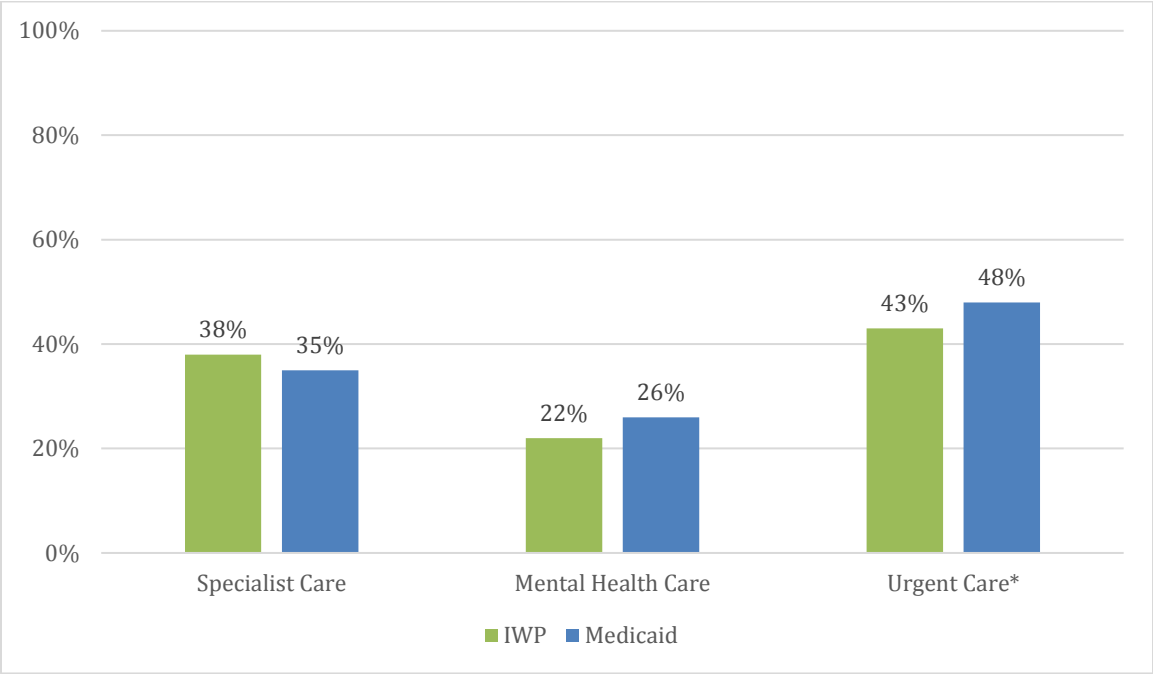
* Statistically significant difference at p<.05

Need for specialty care services was assessed by asking:

- if there was a time when they or a doctor thought they needed care from a specialist
- if they or a health care provider believed they needed any treatment or counseling for a mental or emotional health problem
- if they had an illness, injury or condition that needed care right away (need for urgent care)

Figure 11 provides the need for specialty care services for IWP and Medicaid members. There were no statistically significant differences in need for specialty or mental/emotional health care between IWP and Medicaid members. A little over one-third of members reported a need for specialty care and around one-quarter reported a need for mental/emotional health care. However, significantly more Medicaid members (48%) reported a need for urgent care compared to IWP members (43%).

Figure 11. Need for Specialty Care-Related Services (IWP vs Medicaid)



* Statistically significant difference at p<.05

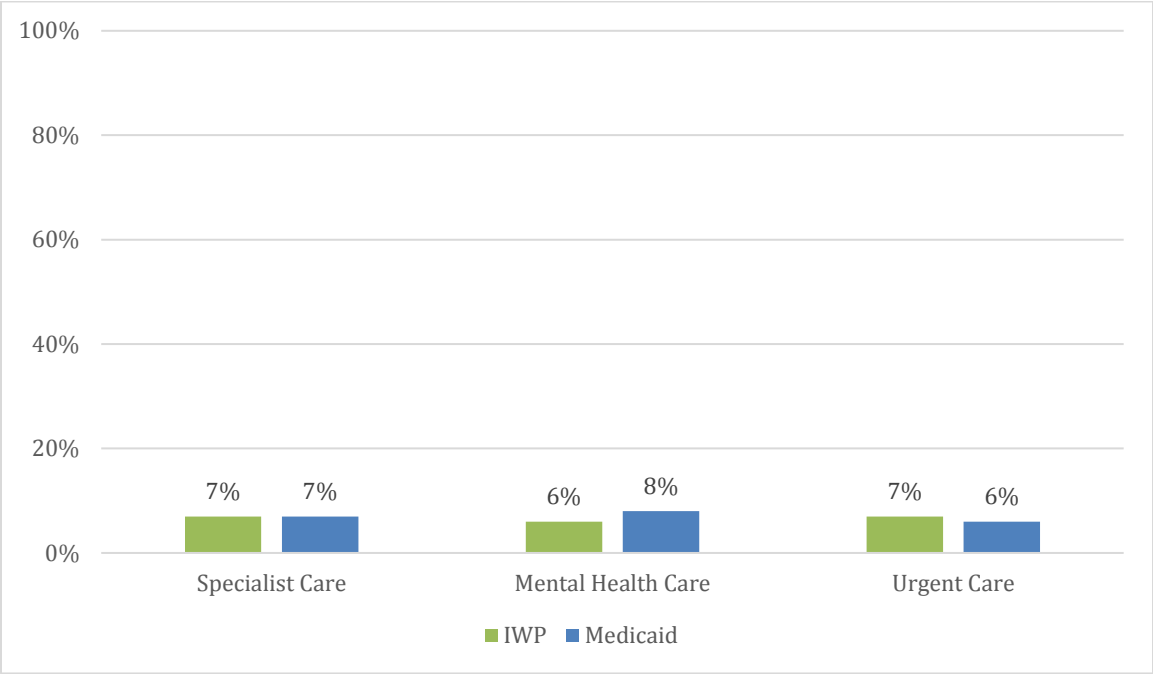
Access to Specialty Care Services: Unmet Need for Care

The survey included the following questions about unmet need for specialty services in the six months prior to the survey:

- For those who reported a need for seeing a specialist: Was there any time when you needed care from a specialist but could not get it for any reason?
- For those who reported a need for mental or emotional health care: Was there any time when you needed treatment or counseling for a mental or emotional health problem but could not get it for any reason?
- For those who reported a need for care right away (urgent care): Was there any time when you needed care right away but could not get it for any reason?

Figure 12 provides a comparison of IWP and Medicaid with regard to unmet need for specialty care services. There were no significant differences in unmet need for these services between IWP and Medicaid members. Overall, for IWP and Medicaid members, around 7% reported an unmet need for a specialist, 7% reported an unmet need for mental health care, and 6% an unmet need for urgent care.

Figure 12. Unmet Need for Specialty Care-Related Services (IWP vs Medicaid)



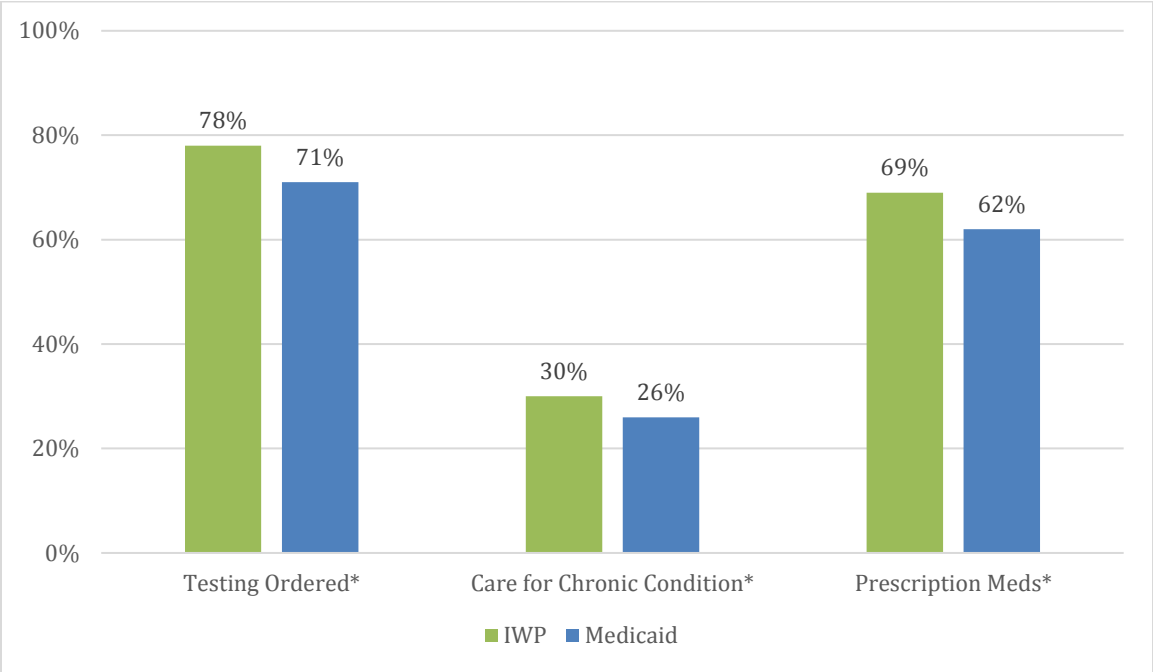
Note: The graph shows the percentage of unmet need for the total sample.

Measure 8 Prescription medication

Diagnostic or treatment service use in the six months prior to the survey included a doctor's office ordering a blood test, x-ray, or other test, any experience receiving health care 3 or more times for a condition or problem that had lasted for at least 3 months, and reported use of prescription medication (excluding birth control).

Figure 13 provides the results of the comparison of diagnostic or treatment service utilization between IWP and Medicaid members. Significantly more IWP members (78%) reported that a doctor's office ordered tests for them when compared to Medicaid members (71%). Also, significantly more IWP members received health care for a chronic condition (30%) than Medicaid members (26%). Finally, significantly more IWP members (69%) reported having used a prescription medication in the previous six months compared to Medicaid members (62%).

Figure 13. Diagnostic or Treatment Services Used by IWP vs Medicaid Members



* Statistically significant difference at p<.05

Hypothesis 1.2

Iowa Wellness Plan members will have equal or greater access to preventive care services.

Measure 9 Breast cancer screening

Percent of women 50-64 who had a mammogram to screen for breast cancer

Definition

This measure protocol is derived from HEDIS 2018 (see also NQF 0031; CMS adult core measure #3). It includes women 50-64 that were eligible for at least 11 months in the measurement year and in for at least 11 months each of the two years prior to the measurement year. The measure provides the percentage of these women that had a mammogram to screen for breast cancer. For example, for the measurement year CY 2017 only women eligible for at least 11 months in each of CY 2017, CY 2016, and CY 2015 are included in the results.

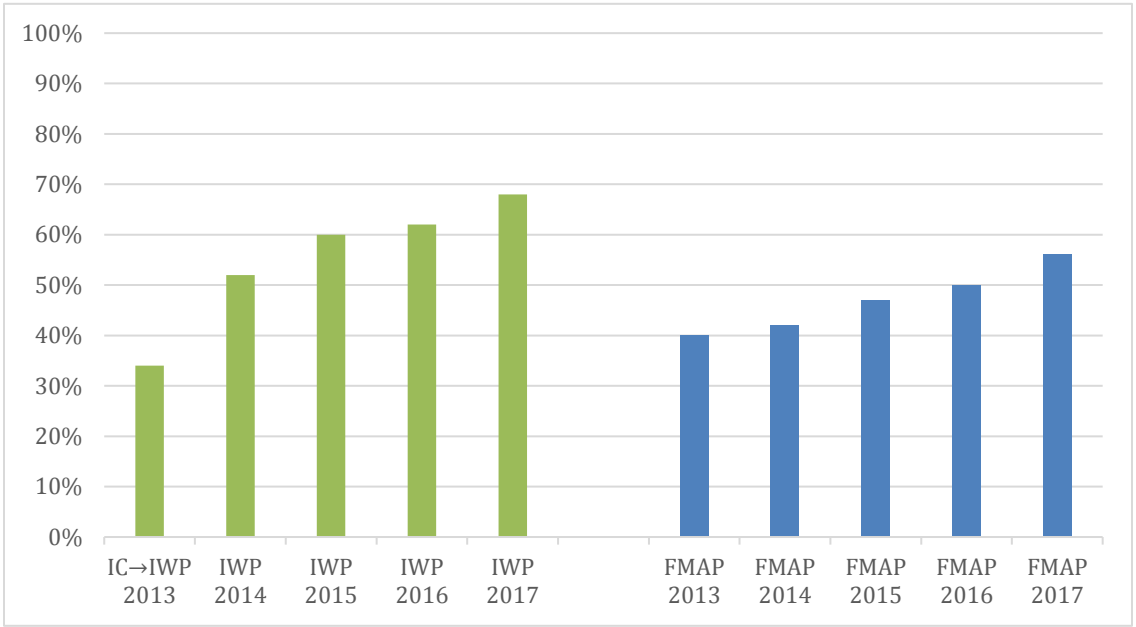
Results

Table 6 and **Figure 14** provide the proportion of women ages 50-64 who had a mammogram by program and year. Rates were consistently the highest among women in IWP from CY 2014 – CY 2017.

Table 6. Percent of women ages 50-64 who had a mammogram CY 2013-CY 2017

Age		FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
50-64 years	#	122	1,125	144	1,827	149	1,855	246	4,430	332	6,116
	%	40%	34%	42%	52%	47%	60%	50%	62%	56%	68%

Figure 14. Percent of women ages 50-64 with a mammogram by program and year, CY 2013 – CY 2017



Whether a woman 50-64 had a mammogram to screen for breast cancer

Due to small numbers of women with a mammogram in the FMAP and IowaCare groups the modelling has been removed from the evaluation.

Measure 10 Cervical cancer screening

Percent of women 21-64 who were screened for cervical cancer

Definition

This measure is derived from HEDIS 2018 (See also NQF 0032; CMS adult core measure #4). It includes women 21-64 that were eligible for at least 11 months in the measurement year and at least 11 months in each of the two years prior to the measurement year. This measure provides the percentage of these women that were screened for cervical cancer.

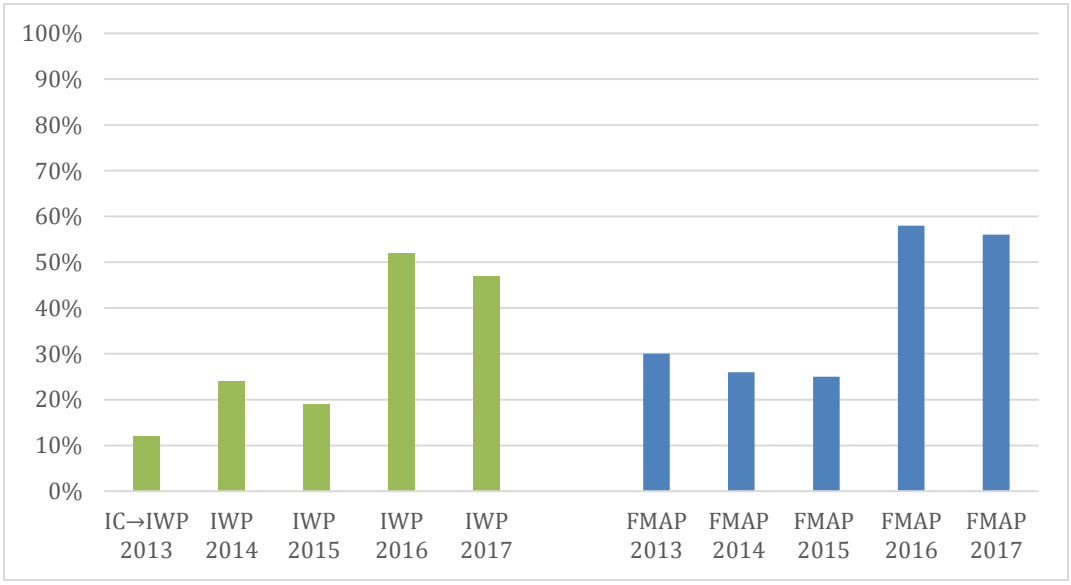
Results

Table 7 and **Figure 15** provide the proportion of women ages 21-64 who were screened for cervical cancer. The numbers of women screened for cervical cancer are higher than the number screened for breast cancer due to the expanded age range. Rates for cervical cancer screening were higher for women in FMAP than women in IWP across all years. In CY 2016 and CY 2017 the rates were much higher for both groups.

Table 7. Percent of women ages 21-64 who had cervical cancer screening CY 2013 - CY 2017

Age		FMAP 2013	IC→WP 2013	FMAP 2014	WP 2014	FMAP 2015	WP 2015	FMAP 2016	WP 2016	FMAP 2017	IWP 2017
21-64 years	#	4,385	1,866	4,204	4,861	4,263	5,822	6,424	11,094	6,728	12,647
	%	30%	12%	26%	24%	25%	19%	58%	52%	56%	47%

Figure 15. Percent of women ages 21-64 with cervical cancer screening by year and program, CY 2013 – CY 2017



Measure 11 Flu shots in past year (administrative data)

Data for this measure is not available due to the various sources for flu shots. Though flu shots are covered under the Medicaid program, we are unable to capture flu shots provided at retail outlets or public health sources that do not bill Medicaid.

Measure 12 Chlamydia screening in past year

This measure was removed due to unreliability of determining whether members were sexually active.

Measure 13 Comprehensive diabetes care: Hemoglobin A1c

Percent of members with type 1 or type 2 diabetes who had Hemoglobin A1c testing

Definition

This measure is derived from HEDIS 2018 (See also NQF 0057; CMS adult core measure #19). Though there are seven components of comprehensive diabetes care as listed below only 3 can be calculated using administrative data alone.

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- HbA1c control (<7.0%) for a selected population
- Eye exam (retinal) performed
- Medical attention for nephropathy
- BP control (<140/90 mm Hg)

Hemoglobin A1c testing, having received an eye exam, and medical attention for nephropathy can be calculated using only administrative data. Hemoglobin A1c testing provides evidence that the glucose levels for members with diabetes are being monitored, which should lead to a reduction in poor outcomes such as neuropathy or diabetic retinopathy. Additionally, in CY 2017, the proportion of members with diabetes having an eye exam or receiving medical attention for nephropathy were added to indicate whether members with diabetes were being monitored for early signs of negative outcomes. For this measure, members with diabetes had to be eligible for 11 months in both the measurement year and the year prior to the measurement year.

Results

IWP consistently had a higher proportion of members diagnosed with diabetes than FMAP, as might be expected as IWP members tended to be older and more likely to have a chronic condition (**Table 8**, **Figure 16**). Members with diabetes in IWP were more likely to have a hemoglobin A1c than those in FMAP, though the rates for both groups fell over time (**Table 8** and **Figure 17**). IWP members with diabetes were less likely to have had an eye exam and more likely to have had medical attention for nephropathy providing mixed results for monitoring of early signs of negative outcomes.

Table 8. Proportion of population age 19-64 identified as having diabetes CY 2013-CY 2017

	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Proportion with diabetes	4%	9%	5%	10%	5%	10%	8%	12%	8%	12%
Hemoglobin A1c rate	86%	90%	84%	89%	83%	90%	75%	84%	75%	82%
Eye Exam									61%	55%
Attention for Nephropathy									79%	81%

Figure 16. Proportion of members diagnosed with diabetes by program and year

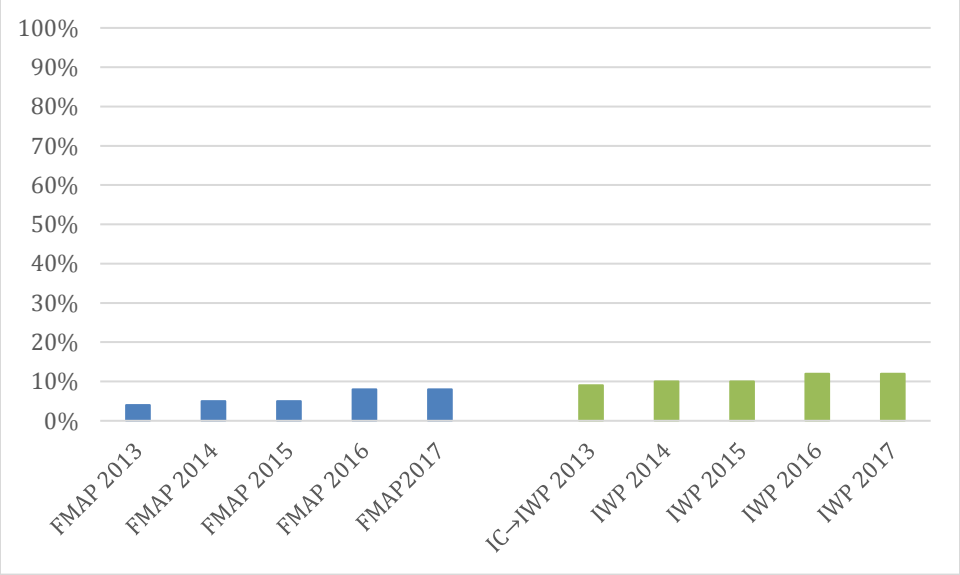
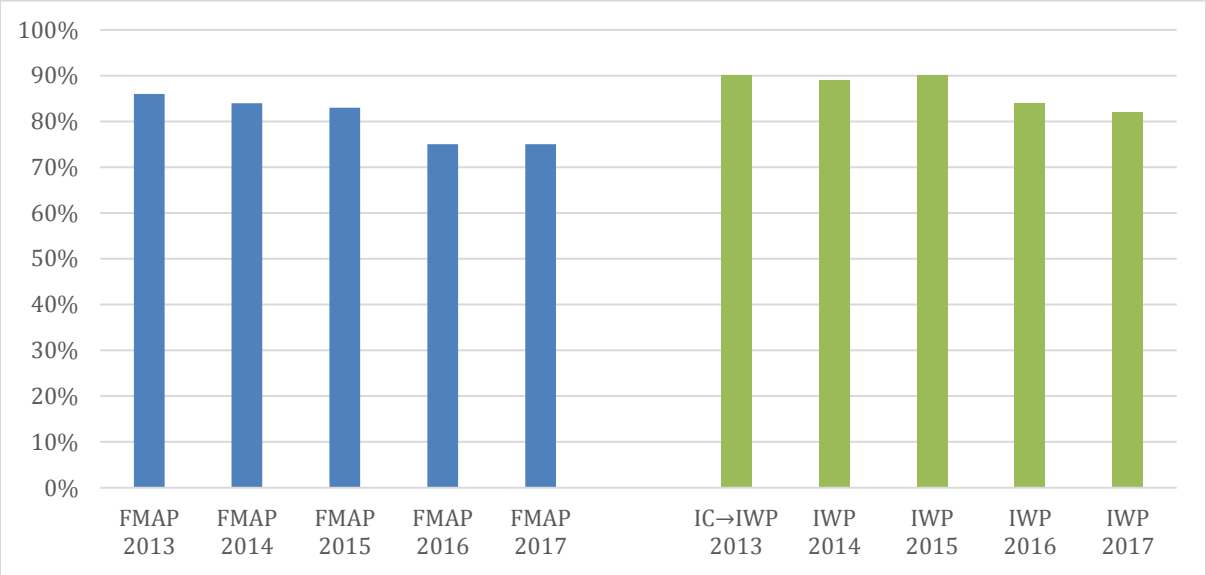


Figure 17. Proportion of population age 19-64 identified as having diabetes and receiving a hemoglobin A1c test



Measure 14 Comprehensive diabetes care: LDL-C screening

Percent of members with type 1 or type 2 diabetes who had LDL-C screening

Definition

LDL-C screening for people with diabetes was originally contained within the comprehensive diabetes measure, however in CY 2015 it was retired from this measure and included in a joint measure calculating the rate of LCL-C screening in people with diabetes and schizophrenia. Since the IWP evaluation had never included members with schizophrenia in the LDL-C screening measure, it remains a measure only for those with diabetes. This measure is derived from HEDIS 2018.

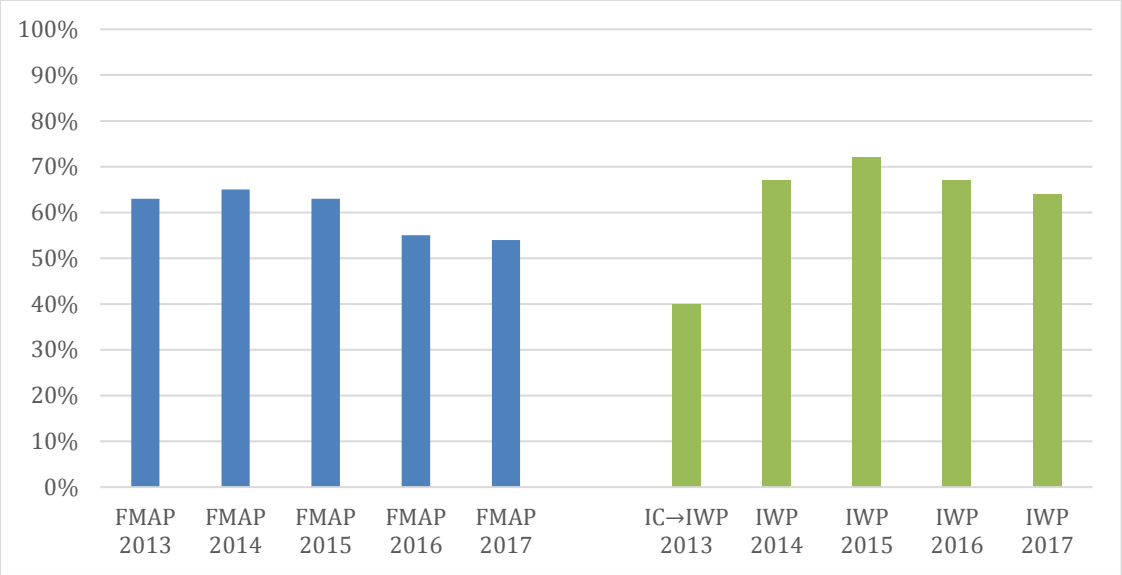
Results

The rate of LDL-C screening for members with diabetes is much lower than that for hemoglobin A1c with a different pattern between the programs and years (**Table 9** and **Figure 18**). Rates of LDL-C screening in IWP members with diabetes were higher than the rates for FMAP members with diabetes for all four years.

Table 9. Proportion of population age 19-64 identified as having diabetes with LDL-C screening CY 2013-CY 2017

	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Proportion with diabetes	4%	9%	5%	10%	5%	10%	7%	11%	8%	12%
LDL-C rate	63%	40%	65%	67%	63%	72%	55%	67%	54%	64%

Figure 18. Proportion of population age 19-64 identified as having diabetes with LDL-C screening CY 2013-CY 2017



Measure 15 Annual monitoring for patients on persistent medication

Definition

This measure derives from HEDIS 2018 (See also NQF 2371). It provides the percent of members on a persistent medication (supplied at least 180 days of ACE/ARB, digoxin, diuretic, or anti-convulsant in the measurement year) who were monitored during the measurement year. Due to the small number of members on persistent medications, this measure is limited to monitoring for members on diuretics. This measure does not include IowaCare members, as the program did not provide prescription drug coverage.

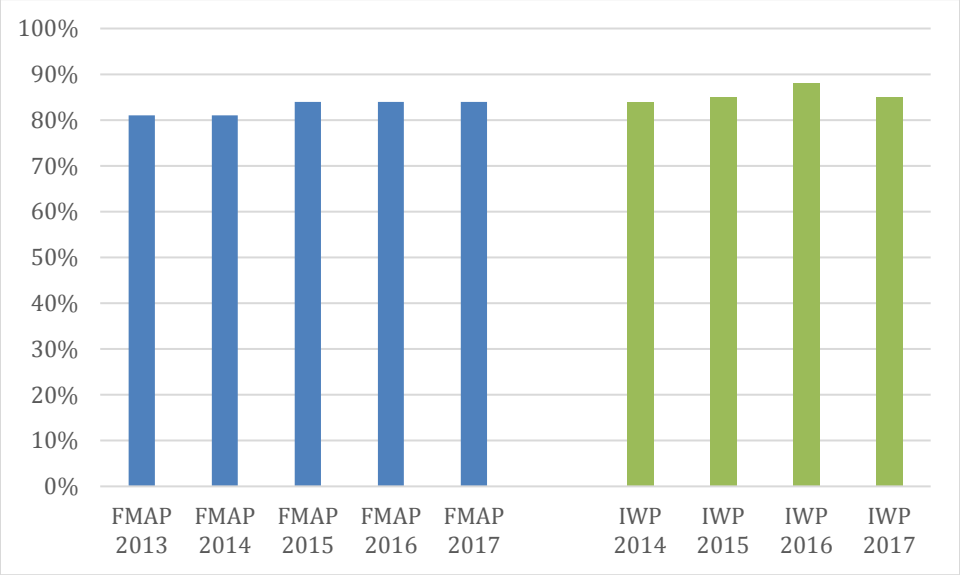
Results

Table 10 and **Figure 19** illustrate the proportion of members who were eligible for at least 11 months during the measurement year and on a diuretic for at least 180 days during the measurement year who received monitoring through a serum potassium or serum creatinine level. Initial rates of screening for IWP were comparable to or higher than the rates of screening for FMAP members for all four years.

Table 10. Proportion of population on diuretic medications screened for potassium and creatinine CY 2013-CY 2017

	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Proportion on diuretic	2%	N/A	2%	5%	2%	5%	4%	8%	2%	3%
Monitoring rate	81%	N/A	81%	84%	84%	85%	84%	88%	84%	85%

Figure 19. Proportion of population on diuretic medications monitored for changes in potassium and creatinine, CY 2013 – CY 2017



Measure 16 Preventive care

See results under Measure 4.

Hypothesis 1.3

Iowa Wellness Plan members will have equal or greater access to mental and behavioral health services.

Measure 17 Anti-depressant medication management

Measure 17 has been removed from the evaluation due to most members with mental illness being moved into the medically frail group or the existing Integrated Health Home program, both of which remove them from our analyses and provide additional access for members with mental illness.

Measure 18 Mental health utilization

Measure 18 has been removed from the evaluation due to most members with mental illness being moved into the medically frail group or the existing Integrated Health Home program, both of which remove them from our analyses and provide additional access for members with mental illness.

Measure 19 Behavioral/emotional care

See Measure 7 Specialty Care.

Hypothesis 1.4

Iowa Wellness Plan members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.

Measure 20 Non-emergent ED use

Definition

The number of non-emergent ED visits per 1,000 member months (total number of months that people are eligible across all members) is calculated using all members in the program. The NYU ED algorithm is used to determine the degree to which the ED visits in a given year for a given program were non-emergent[3]. Each visit is provided with a number between 0 and 1 that indicates the degree to which it may be considered non-emergent. These are summed for all visits in the measurement year across all visits made by members and then divided by the total number of member months and multiplied by 1,000.

Results

The number of non-emergent ED visits per 1,000 members in FMAP was much higher than for members in IC in 2013. This was due, in part, to the IC program policy of reimbursing only ED visits that occurred at the University of Iowa Health Care in Iowa City or Broadlawns Medical Center in Des Moines, leaving many ED visits out of the Medicaid claims data. Members in IWP did not have these restrictions leading to an increase in the number of non-emergent ED visits as compared to IC members prior to implementation of IHAWP. Following the introduction of the IWP, the numbers of non-emergent ED visits were consistently below those for FMAP members from CY 2014 – CY 2017 (**Table 11**).

Table 11. Number of non-emergent visits per 1,000 member months, CY 2013-CY 2017

	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Number of non-emergent visits/1,000 member months	23.2	7.7	23.0	12.3	22.2	12.9	21.1	15.6	23.2	16.5

Measure 21 Follow-up ED visits

Definition

We developed a measure for ED readmission based on the HEDIS 2018 Plan all-cause readmissions measure as the percent of members with an emergency department (ED) visit within the first 30 days after an index ED visit may indicate a lack of access to primary care for ED follow-up and ongoing management of an acute problem originally treated in the ED.

[3] https://wagner.nyu.edu/faculty/billings/nyued-background

Results

The rates of ED visits and follow-up ED visits for IWP members are lower than for FMAP members for all four years, CY 2014-CY 2017 (**Table 12**).

Table 12. Proportion of members age 19-64 eligible for at least 11 months identified as having an index ED visit with at least one ED readmission within 30 days, CY 2013-CY 2017

	FMAP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Proportion with index ED visit	68%	42%	67%	66%	71%	69%	49%	37%	44%	35%
Proportion with ED readmission	29%	19%	30%	24%	28%	23%	29%	27%	28%	26%

Measure 22 Ambulatory Care

Definition

This measure is derived from HEDIS 2018. It summarizes utilization of outpatient visits and emergency department (ED) visits as a rate per 1,000 member months for those ages 19-64 years enrolled for at least one month during the measurement year.

Results

The rate of ED visits/1,000 member months was higher for FMAP members for all four years however, the rates for IWP members increased from CY 2014 – CY 2016 before dropping slightly in CY 2017 (**Table 13**). The ED rates/1,000 member months for FMAP members and IWP members began to converge in CY 2016 (**Figure 20**). During this same time frame, the rate of ambulatory care visits increased from nearly 200 per 1,000 member months in CY 2013 to over 300 per 1,000 member months in CY 2017, while the rate of ambulatory care visits decreased for FMAP members (**Figure 21**). By CY 2017 the rate of ambulatory care visits for IWP members is very close to the rate for FMAP members.

Table 13. Number of ED visits and number of ambulatory care visits per 1,000 member months for members 19-64 years of age CY 2013-CY 2017

	IWP 2013	IC→IWP 2013	FMAP 2014	IWP 2014	FMAP 2015	IWP 2015	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
ED visits/1,000 member months	106.4	34.7	104.1	65.9	103.5	68.4	100.9	78.6	95.5	70.4
Ambulatory care visits/1,000 member months	398.9	197.0	422.3	316.1	452.4	346.4	374.4	344.8	326.8	300.4

Figure 20. ED visits per 1,000 member months by program and year, CY 2013-CY 2017

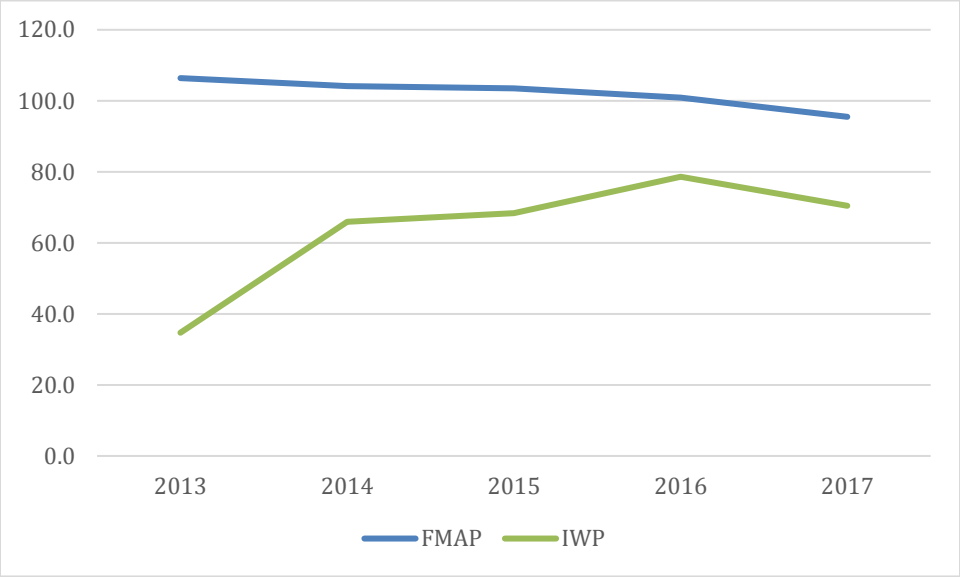
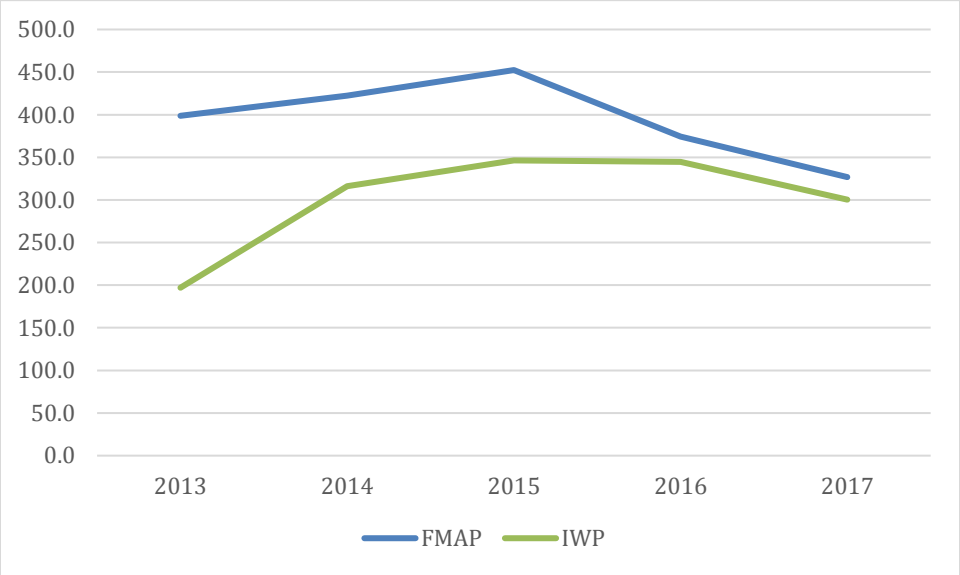


Figure 21. Ambulatory care visits per 1,000 member months by program and year, CY 2013-CY 2017



Hypothesis 1.5

Iowa Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.

Measure 23 Barriers to care due to transportation

NEMT is a mandated benefit for Medicaid members. However, the state of Iowa received a waiver of this mandate for its Medicaid expansion population. Therefore, NEMT is not mandated for members in IWP. To evaluate the

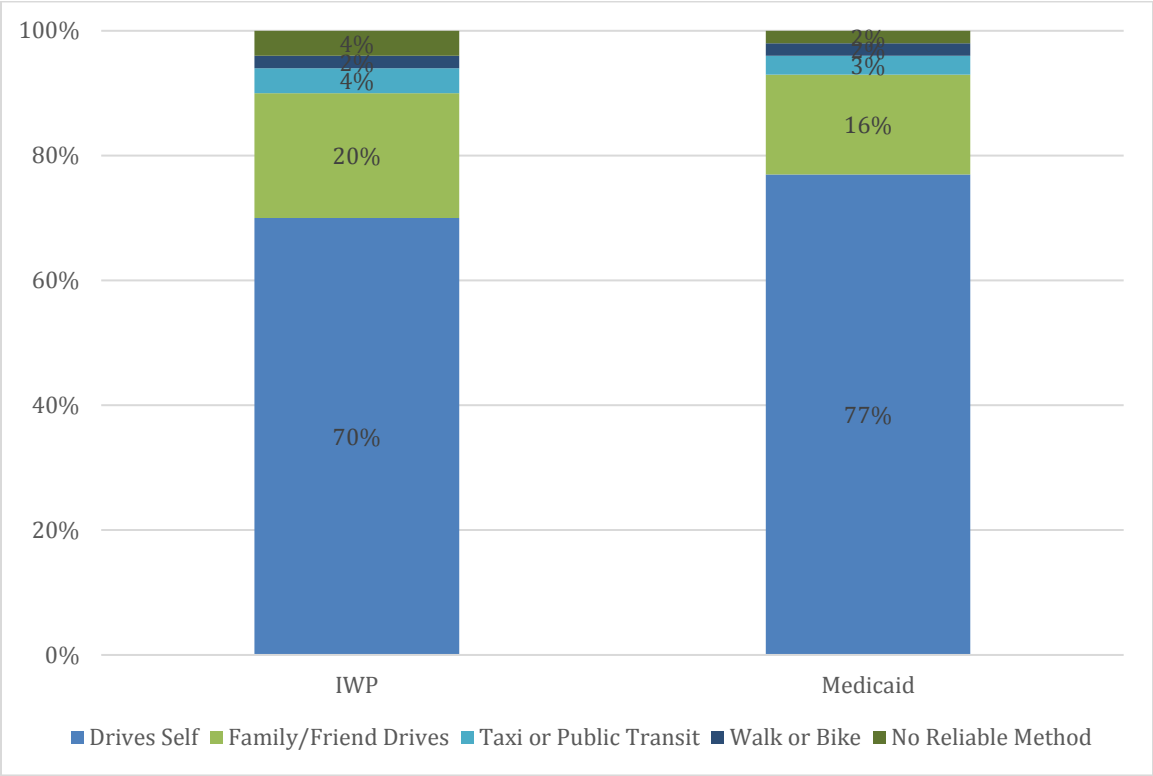
effects of waiving the NEMT benefit, transportation-related questions in the surveys covered the following topic areas:

- Mode of Transportation to Health Care Visits
    - The enrollees' mode of traveling for health care
- NEMT Assistance Issues
    - How frequently they needed assistance traveling for health care in the last 6 months
    - Unmet need for NEMT in the last 6 months
    - Concern about costs associated with NEMT in the last 6 months
    - Use and ease of use of NEMT paid for by their MCO
- Transportation Problems as a Barrier to Specific Health Care Services
    - Transportation as a barrier to going to the doctor's office or clinic instead of the emergency department for care
    - Transportation as a barrier to obtaining a ***medical*** check-up (only asked of IWP members)
    - Transportation as a barrier to obtaining a ***dental*** check-up (only asked of IWP members)

Mode of Transportation to Health Care Visits

In the surveys, members were asked: *"When you need to get health care, what is the type of transportation you use most often to get to your visit?* (Please choose only one answer.)" The majority of respondents of both groups drove themselves (70% IWP, 77% Medicaid) or were driven by family or friends (20% IWP, 16% Medicaid) to their health care appointments. Overall, few members reported having no reliable way to get to health care visits; however, there were significantly more IWP members reporting unreliable transportation (4%) when compared to Medicaid members (2%). Yet, within IWP, there were no significant differences by MCO in reporting of no reliable transportation to health care visits. **Figure 22** provides a summary of the responses from both IWP and Medicaid members.

Figure 22. Modes of Transportation to Health Care Visits (IWP vs Medicaid)



NEMT Assistance Issues

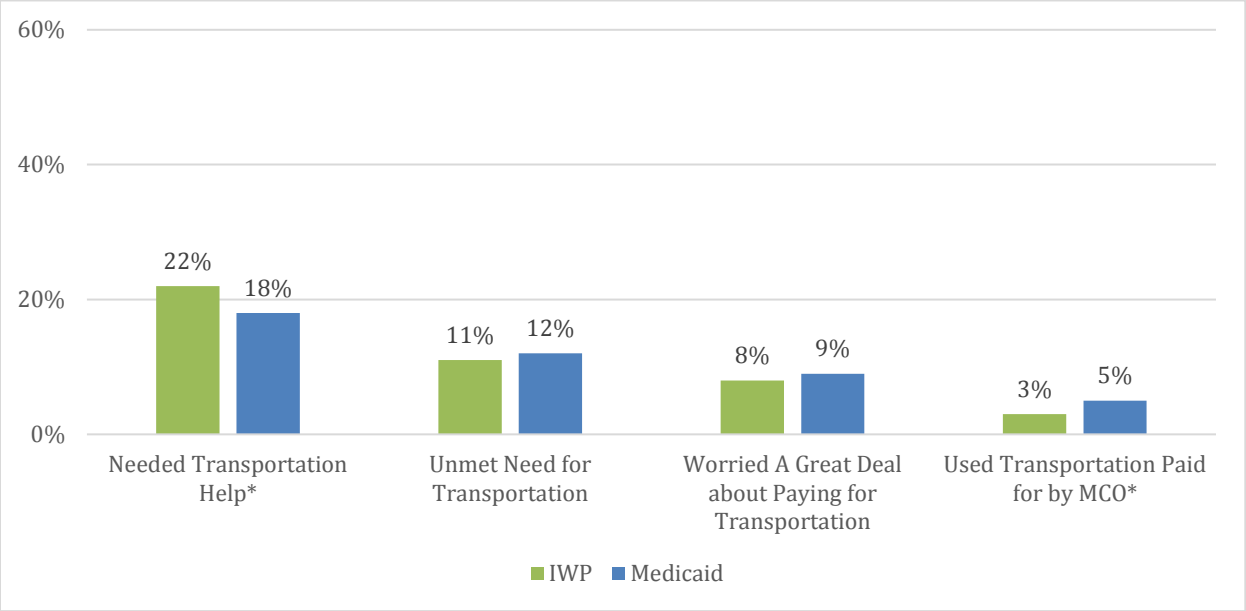
Four questions were specific to transportation assistance issues:

1. In the last 6 months, how often did you need assistance from other sources (such as friends, family, public transportation, etc.) to get to your health care visit?
2. In the last 6 months, was there any time when you needed transportation to or from a health care visit but could not get it for any reason?
3. In the last 6 months, how much, if at all, have you worried about your ability to pay for the cost of transportation to or from a health care visit?
4. Since joining your MCO, have you ever used transportation paid for by your MCO to get to or from a health care visit? If yes, how easy was it for you to use the transportation services provided by your MCO?

Figure 23 summarizes the responses to these questions for IWP and Medicaid members. Significantly more IWP members (22%) reported usually or always needing help from other sources to get to health care visits compared to Medicaid members (18%). The reported unmet need for transportation was not statistically different for Medicaid members (12%) and IWP members (11%). There was no statistical difference between Medicaid and IWP in reported worry about the cost of transportation with around 8% of each reporting that they worried "a great deal" about their ability to pay for the cost of transportation to or from a health care visit.

Significantly more Medicaid members (5%) reported having used transportation paid for by their MCO to get to or from a health care visit when compared to IWP members (3%). For those who did use transportation paid for by their MCO, a little over half (58%) of Medicaid and IWP members reported that it was "very easy" to use the transportation services provided by their MCO.

Figure 23. Transportation Issues Experienced by IWP vs Medicaid Members



* Statistically significant difference at p<.05

Transportation Problems as a Barrier to Specific Health Care Services

The surveys included three questions about transportation as a barrier to accessing specific health care services. For these questions, respondents were asked to give reasons why they were not able to obtain particular health care services with difficulty getting transportation as a listed response.

On both the IWP and Medicaid surveys, the following question was asked of respondents:

> Do you think the care you received at your most recent visit to the ER could have been provided in a doctor's office if one was available at the time? If so,
>
> - What was the main reason you did not go to a doctor's office or clinic for this care [care received at the emergency room (ER) that could have been provided at a doctor's office or clinic]?
>
> Transportation-related response option: "I had transportation problems getting to a doctor's office or clinic"

Few members cited transportation issues as the main reason for using the ED instead of their doctor's office. Around 2.5% of IWP and Medicaid members (3% IWP, 2% Medicaid) reported transportation problems as the main reason for using the emergency room instead of their doctor's office.

A programmatic difference between IWP and Medicaid is the expectation of IWP members that they will get either a medical check-up or dental check-up in order **to keep from having to pay a premium** for their health care. Due to this difference, the following two questions were only included on the IWP surveys:

> Do you think any of the following would keep you from getting a medical check-up this year?
>
> Transportation-related response option: "Getting transportation to my doctor's office is hard"
>
> AND
>
> Do you think any of the following would keep you from getting a dental check-up this year?
>
> Transportation-related response option: "Getting transportation to my dentist's office is hard"

For IWP members, transportation difficulties were the fifth most reported barrier to obtaining a medical and dental check-up (approximately 5% self-report across all three MCOs).

Measure 24 EPSDT utilization

Measure 24 was removed due to the small number of members eligible for IWP with EPSDT benefits and not in a transitional program allowing young adults to remain on Medicaid State Plan until they turn 21.

Churn

Question 2 *What are the effects of the Iowa Wellness Plan on member insurance coverage gaps and insurance service when their eligibility status changes (churning)?*

Hypothesis 2.1

Iowa Wellness Plan members will experience equal or less churning.

Iowa Wellness Plan members experienced equal or more churning than FMAP members.

Additional findings

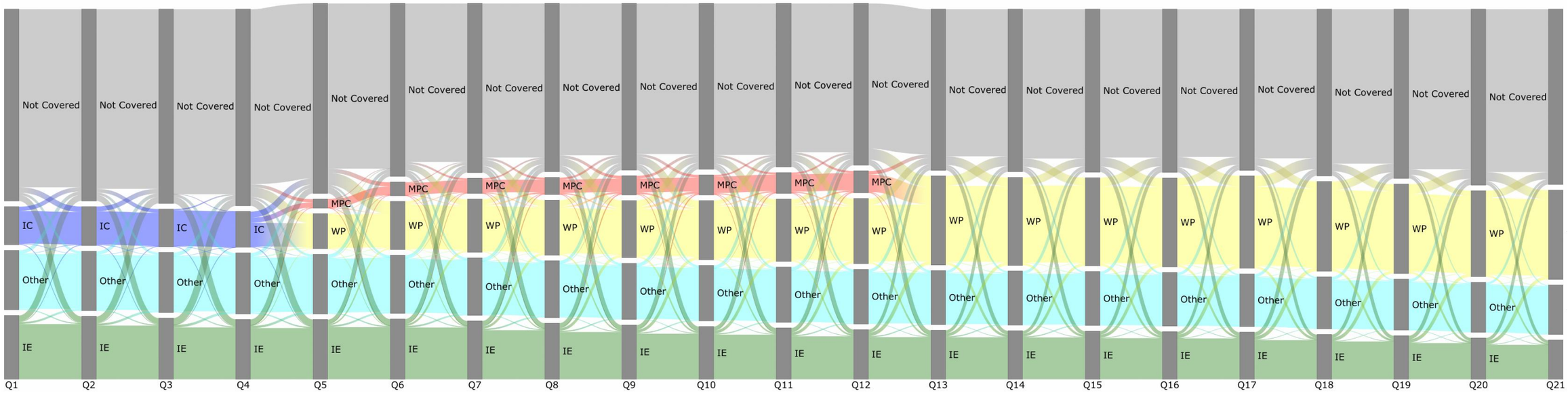
The movement of IWP members in and out of the Medicaid program and between MCOs is not practically different than that for a comparable study group, namely FMAP members. A few findings are worth noting.

1. There are significant numbers of members losing coverage in both programs and further study is needed to determine whether this is a positive result (have other coverage) or a negative result (uninsured).
2. The vast majority of transitions were from MCO 3 to MCO 1 or MCO 2 for both groups. Understanding why these transitions occurred is important to determine whether they are related to the satisfaction with and experience members have in each of these MCOs.
3. We continue to see that people of color and males are less likely to remain covered within Medicaid. Special emphasis should be placed on determining why this disparity exists.

Figure 24 visualizes Medicaid program churn from the 1st quarter 2013 through the 4th quarter 2017. This figure includes any member enrolled for at least 1 month in any Medicaid program from CY 2013 through CY 2017 as contained in the enrollment file for March 2018. Within the figure, lines moving away from the program from left to right indicate a movement out of the program, while lines moving toward the program from left to right indicate movement into the program. The thickness of the line is related to the number of members making a move. A thicker line indicates more members are moving. For example, the line portraying movement from IC to WP is thicker than the line portraying movement from IC to MPC from Q4 to Q5 because more members moved to WP than MPC.

Within the figure, FMAP member numbers remain stable, as does the number of members in other Medicaid programs including Supplemental Security Income (SSI). Within the last 2 years, the bulk of members have moved from MPC in IWP as expected when MPC became a dormant program. Since January 2016, the movement in and out of programs seems to be relatively stable with no large groups of members moving into or out of any program.

Figure 24. Churn in Medicaid programs, 1st Quarter 2013 through 4th Quarter 2017



IC=IowaCare Other=Other Medicaid programs, including SSI IE=Income Eligible WP=Wellness Plan MPC=Marketplace Choice

Previous reports have provided information on churn following the implementation of IWP. Program churn can be defined as the movement of enrollees into and out of Medicaid programs with or without a gap in coverage. Those results are found at http://ppc.uiowa.edu/health/study/evaluation-iowas-medicaid-expansion-iowa-health-and-wellness-plan.

Members in IWP and FMAP also lost coverage during the period January 2016 – December 2017. 81,336 members lost coverage in the IWP (30%), while 14,308 FMAP members (20%) lost coverage during this time. **Table 14** provides information on those who left IWP and **did not return** to IWP or any other Medicaid program and those who left and **returned** to another program (had a gap in coverage). Those who returned were significantly more likely to be female (p<0.000), white (p<0.000), and younger (p<0.000) than those who did not return.

Table 14. Demographic characteristics of IWP members who left by return status CY 2016 – CY 2017

		Returned N (%)	Did not return N (%)
Gender			
Female	**Number**	19,360	37,533
	%	55%	46%
Male	**Number**	15,967	43,525
	%	45%	54%
Race			
White	**Number**	23,660	49,916
	%	67%	62%
Black	**Number**	3,919	7,406
	%	11%	9%
American Indian	**Number**	659	1,147
	%	2%	1%
Asian	**Number**	735	1,790
	%	2%	2%
Hispanic	**Number**	1,824	4,775
	%	5%	6%
Pacific Islander	**Number**	137	480
	%	0%	1%
Multiple-Hispanic	**Number**	603	1,129
	%	2%	1%
Multiple-Other	**Number**	544	825
	%	2%	1%
Undeclared	**Number**	3,246	13,590
	%	9%	17%
Age			
18-21 years	**Number**	4,165	7,174
	%	12%	9%
22-30 years	**Number**	11,229	25,138
	%	32%	32%
31-40 years	**Number**	8,909	19,328
	%	26%	24%
41-50 years	**Number**	5,572	13,441
	%	16%	17%
51 and over	**Number**	5,072	14,491
	%	15%	18%
County rural/urban status			
Metropolitan	**Number**	21,892	49,703
	%	62%	61%

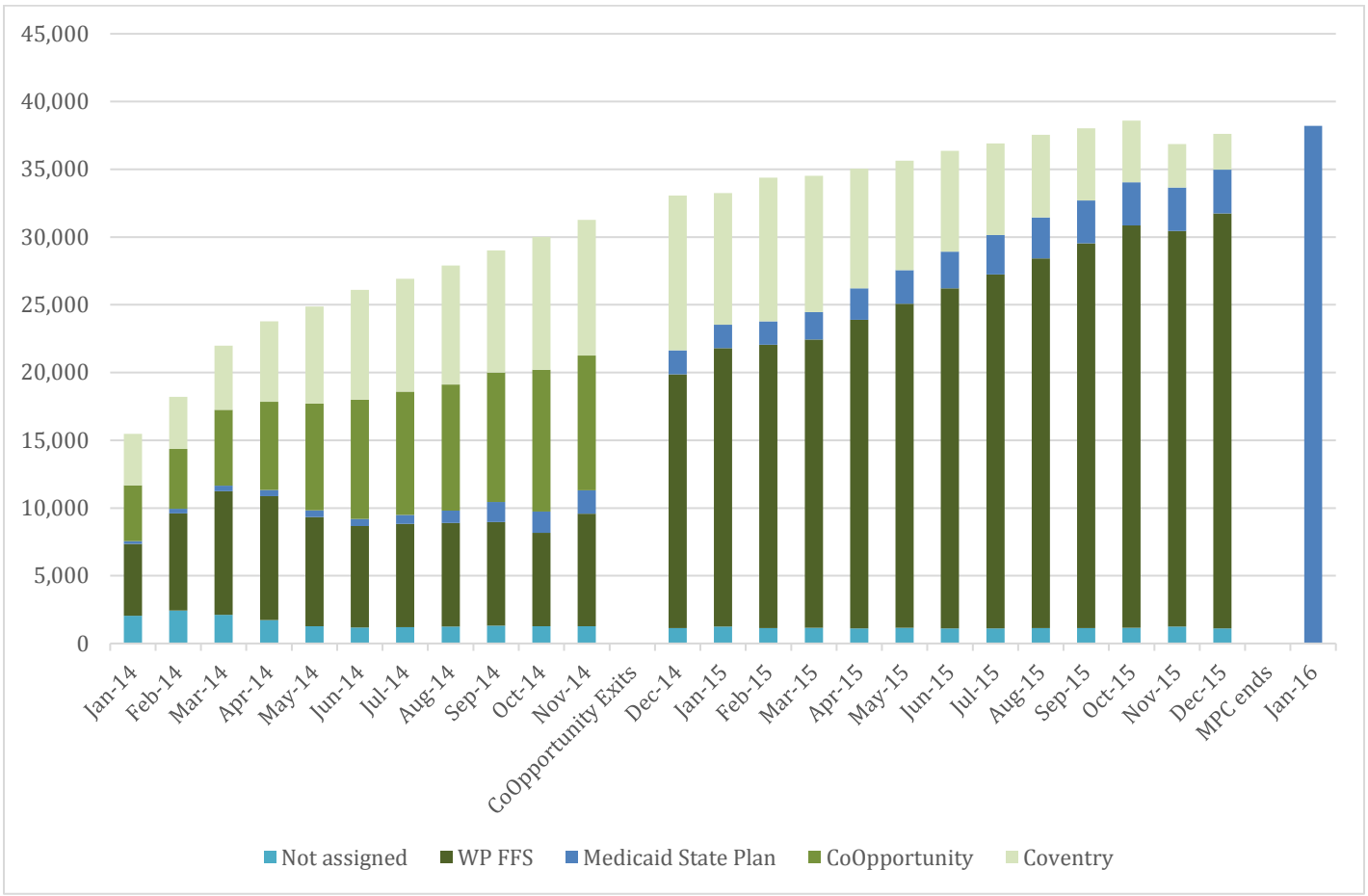
Non-metropolitan, urban	**Number**	1,428	3,677
	%	4%	5%
Non-metropolitan, rural	**Number**	12,007	27,678
	%	34%	34%

Transitions

This report contains information on transitions that occur within the IWP program for the period January 2014 through December 2017. During this time, IWP members who qualified for MPC (income 101-138% FPL), transitioned from QHPs to traditional fee-for-service Medicaid to MCOs. At each transition point members had to determine whether their health care providers were in the new option and, if not, how to access health care. Members who qualified for WP or who qualified for MPC but were determined to be 'medically frail' were not assigned to a QHP but remained in a traditional Medicaid managed care option; either Meridian HMO or the MediPASS primary care gatekeeper program. Additionally, members in MPC may not have been assigned a QHP during the first few months of enrollment.

Figure 25 shows the distribution of members in MPC from January 2014 through December 2015. By December 2014, the point at which CoOpportunity exits, most MPC members who had been enrolled in CoOpportunity had been transitioned to WP fee-for-service coverage, as Coventry was unwilling to add these members to their membership. A smaller proportion of former CoOpportunity members were enrolled in traditional Medicaid fee-for-service. None of these members were enrolled in either Meridian HMO or MediPASS.

Figure 25. Marketplace Choice enrollment, CY 2014 – CY 2015



Wellness plan members were primarily enrolled in MediPASS (WP PCP), (**Figure 26**) with a growing number enrolled in Medicaid fee-for-service from July 2014 through December 2015. This represents members who were deemed 'Medically Frail' and allowed to enroll in Medicaid fee-for-service to take advantage of services not available under Wellness Plan.

Beginning in January 2016, the WP and MPC became IWP. **Figure 27** shows the distribution of IWP enrollment by MCO. The numbers and distribution of members remains stable across the MCOs until November 2017 when MCO 2 exits the Medicaid program. As a result, enrollment in MCO 3 increased dramatically due to the influx of previously-enrolled MCO 2 members.

Figure 26. Wellness Plan enrollment, CY 2014 – CY 2015

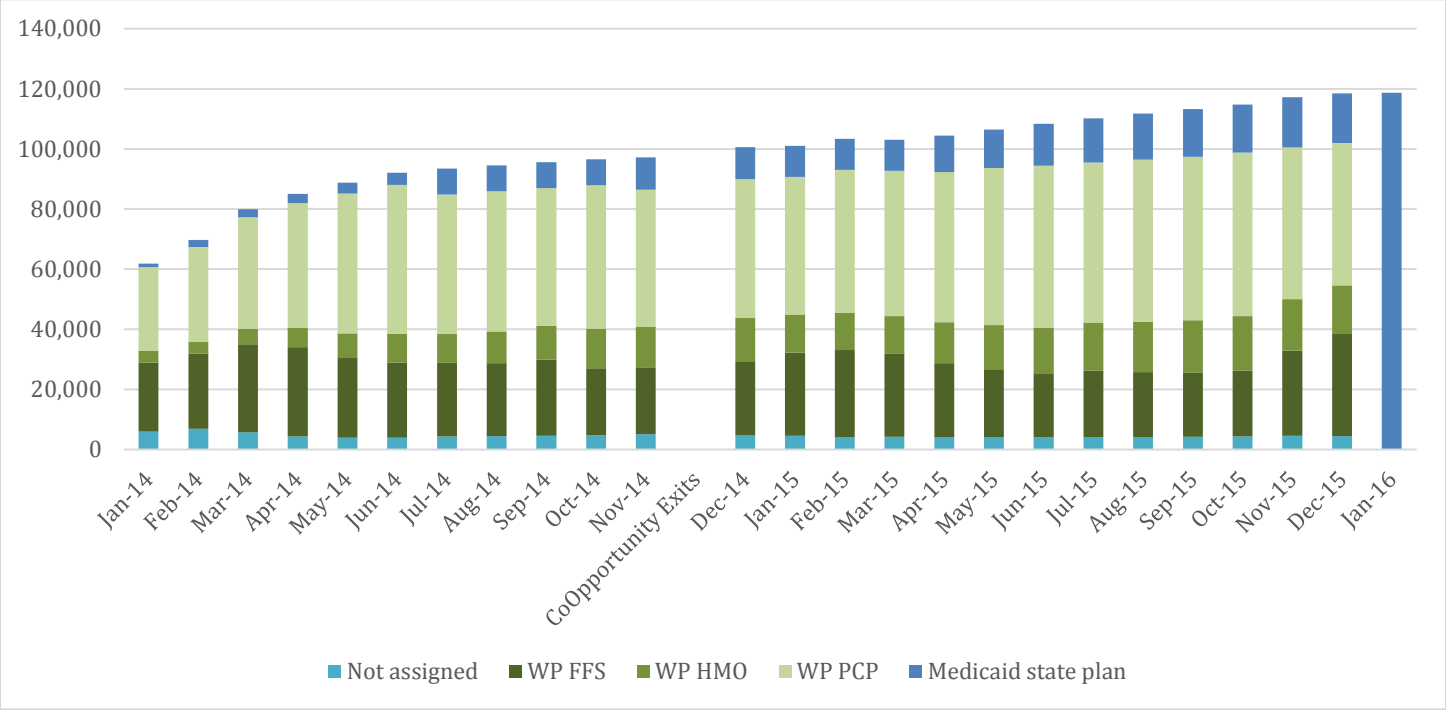
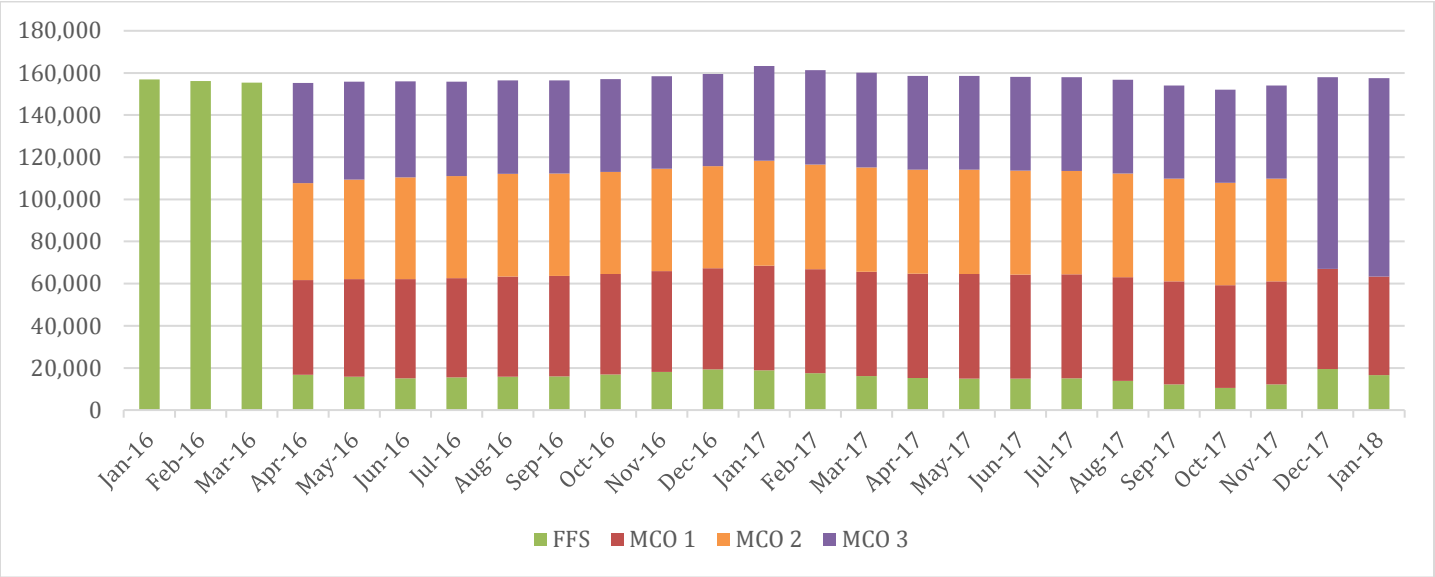


Figure 27. Iowa Wellness Plan enrollment, CY 2016 - CY 2017

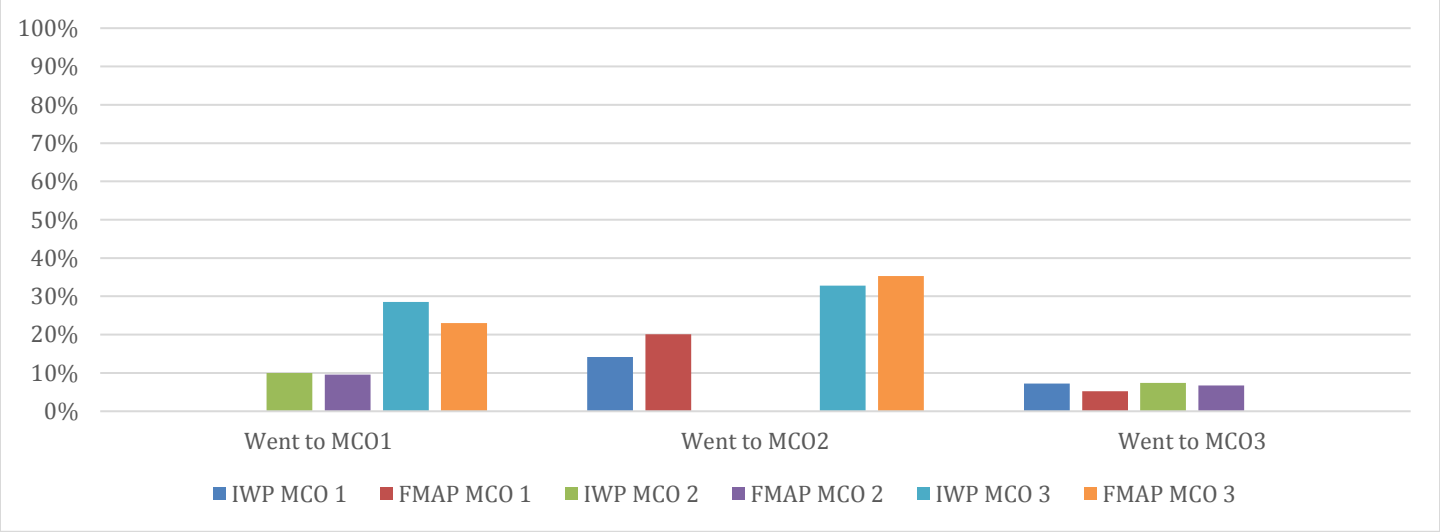


Transitions between MCOs are only allowed during the first 90 days of the first enrollment, the member's open enrollment period after the initial enrollment, and for 'Good Cause'. **Table 15** and **Figure 28** provide the transitions between MCOs for IWP members and FMAP members during the period January 2016 through November 2017 (we avoid December 2017 as this is when all the transitions were completed to move members from MCO 2 to MCO 3). Overall, both groups displayed similar patterns of transitions between MCOs over time.

Table 15. Number and proportion of transitions between MCOs, CY 2016 - CY 2017

			MCO they went to			Total
	MCO they came from		MCO 1	MCO 2	MCO 3	
IWP						
	MCO 1	Count	-	1,770	896	2,666
		%	0%	14%	7%	21%
	MCO 2	Count	1,249	-	922	2,171
		%	10%	0%	7%	17%
	MCO 3	Count	3,558	4,091	-	7,649
		%	29%	33%	0%	61%
	Total	Count	4,807	5,861	1,818	12,486
		%	39%	47%	15%	100%
FMAP						Total
	MCO 1	Count	-	2,852	740	3,592
		%	0%	20%	5%	25%
	MCO 2	Count	1,356	-	951	2,307
		%	10%	0%	7%	16%
	MCO 3	Count	3,256	5,000	-	8,256
		%	23%	35%	0%	58%
	Total	Count	4,612	7,852	1,691	14,155
		%	33%	56%	12%	100%

Figure 28. Proportion of transitions between MCOs, January 2016 - November 2017



Measure 25 Gaps in coverage in past 12 months

Definition

One survey item was used to assess gaps in insurance coverage in the year prior to the survey. Only WP and MPC member surveys included this item. MSP members were not asked this question. The measure was defined in the following way:

> Time without insurance = number of months in the previous year when the respondent did not have health insurance coverage.

Results

Gaps in coverage can be an indicator of positive life changes that result in other insurance or an indicator of negative consequences due to difficulty with continuing coverage requirements. Within the eligibility data, it is not possible to determine why members may have a gap period during which they are not covered. However, we are able to determine the number of individuals who experience a gap in coverage during the period January 2016 through December 2017 and ascertain how long the gap is.

The proportion of members with at least one gap does not vary by program. The length of gap is also comparable between FMAP and IWP. Most members experience a gap of only 1 month, indicating a very short duration without coverage. Of interest, the FMAP members are more likely to switch to a different Medicaid program at the end of the gap than IWP members. This may be primarily due to the income requirements within each program and wide variety of programs available to those with incomes under 100% FPL as compared to those with incomes over 100% FPL.

Table 16. Gap experience of FMAP and IWP members, CY 2016 - CY 2017

	FMAP	IWP
At least one gap	8,690 (5%)	34,255 (6%)
1-6 month gap	7,210 (75%)	26,135 (72%)
7-11 month gap	1,574 (16%)	6,609 (18%)
12-16 month gap	837 (9%)	3,750 (10%)
Switched programs during gap	4,291 (45%)	6,672 (18%)

Figure 29. Comparison of IWP and FMAP members with at least one gap, CY 2016 and CY 2017

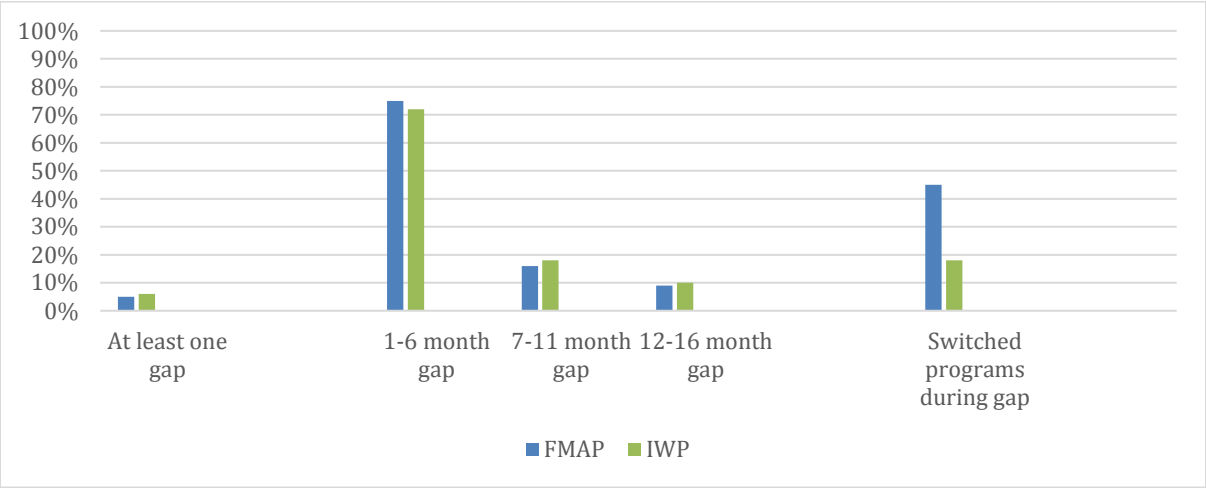
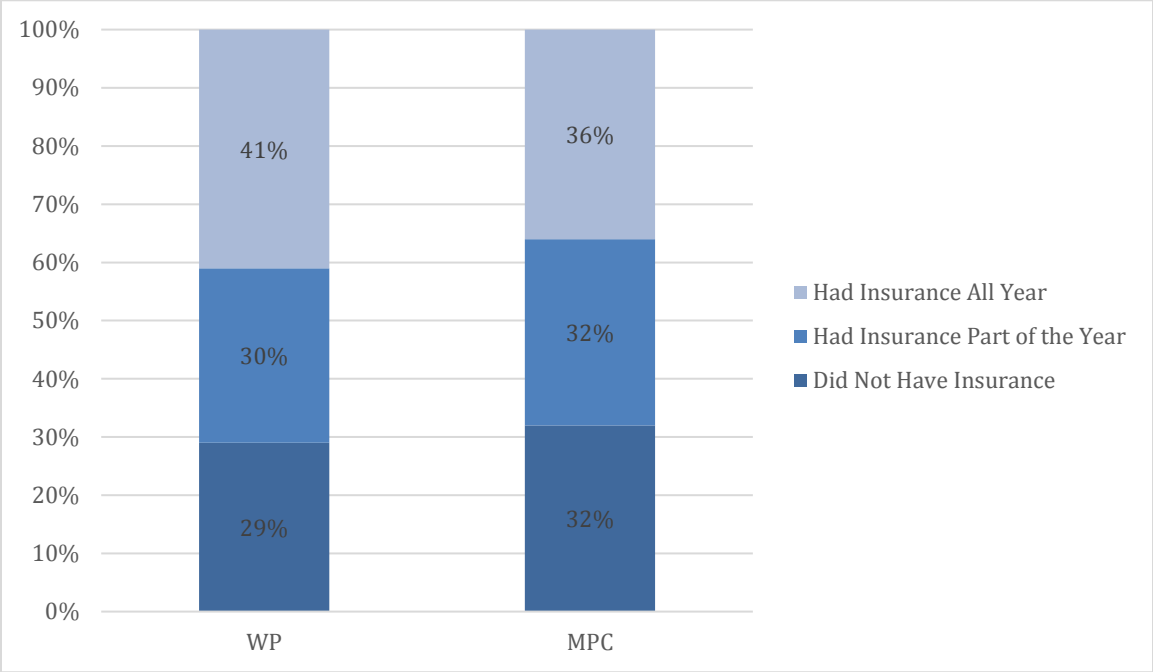


Figure 30 provides a comparison of insurance coverage between WP and MPC members. Around 30% of all IHAWP members reported that they did not have any health insurance coverage in the year prior to the IHAWP. There were no significant differences in past insurance coverage between WP and MPC members.

Figure 30. Insurance Coverage in the Year before IHAWP



Measure 26 Consecutive months covered by an insurance plan

See results under Measure 24.

Measure 27 Number of times member changes plans and/or loses eligibility during the year

Definition

Whether member: 1) did not change plans or lose eligibility; 2) changed plans or lost eligibility once; 3) changed plans or lost eligibility 2-3 times; or 4) changed plans or lost eligibility 4 or more times.

Results

There were 10,042 IowaCare members who were not auto-enrolled into IHAWP. Of those, 2,299 members were subsequently covered through the Medicaid State Plan (MSP) or IHAWP leaving 7,743 not receiving coverage through MSP or IHAWP during CY2014. Those covered through MSP were enrolled through income eligibility (N=501), disability eligibility (N=31), the Family Planning Waiver (a program providing access only to family planning services, N=108), and Medicaid for Employed People with Disabilities (N=2). 1,000 people were subsequently enrolled in WP and 657 were enrolled in Marketplace Choice. The gap between IowaCare coverage and coverage through another program varied from no gap (N=711) to 11 months (N=89) as shown in **Figure 31**.

Figure 31. Gap in coverage for those not auto-enrolled in IHAWP, CY 2014

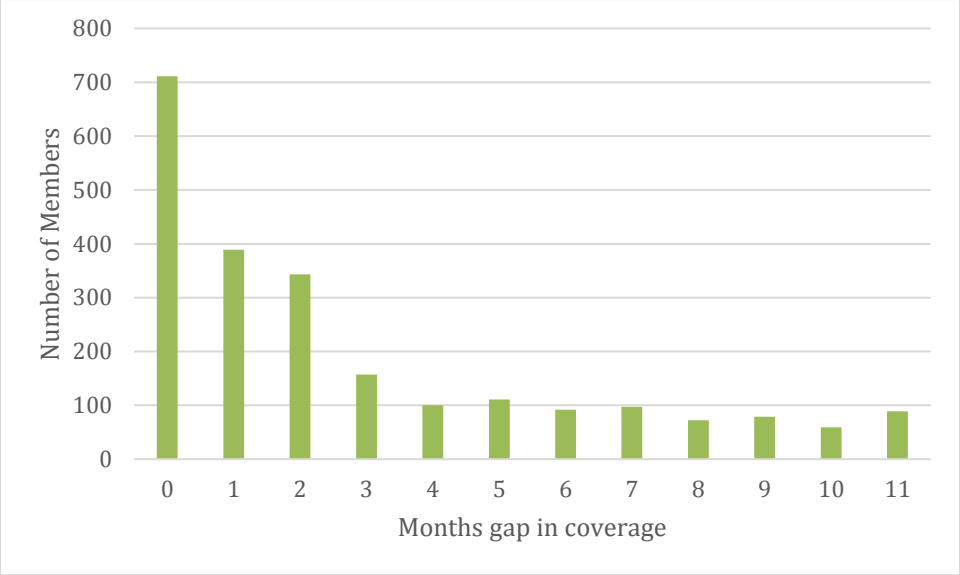


Table 17 provides the number of switches and length of gaps in coverage by program and year for both the year prior to the IHAWP and the first year of the program. Four groups are used in these comparisons: 1) FMAP CY 2013 and CY 2014; 2) IowaCare for CY 2013; 3) WP; and 4) MPC. Though members may have moved between programs, they are categorized according to the program of first enrollment for **Table 17**. A switch is indicated whenever there is a change in program during the year. Members in FMAP are generally the least likely to experience a switch and tend to have the smallest gaps in coverage, while those auto-enrolled from the IowaCare program were most likely to have a switch, however, most of these switches did not involve a gap in coverage. This indicates that there was a change in program commensurate with a change in circumstances. Though changes in program are not always simple or easy for members, those that do not result in gaps of coverage may be considered 'positive' churn within the publicly provided programs.

Table 17. Number and percent of members with at least one switch and the months of gap during switch period by program, CY 2013 and CY 2014

	FMAP CY 2013	IowaCare CY 2013	FMAP CY 2014	WP CY 2014	MPC CY 2014
At least one switch	5,071 (9%)	20,123 (25%)	7,607 (14%)	15,628 (15%)	7,077 (23%)
0 months gap	3,336 (6%)	15,468 (19%)	5,932 (11%)	13,644 (13%)	6,098 (20%)
1-6 month gap	1,315 (2%)	3,573 (4%)	1,319 (2%)	1,805 (2%)	877 (3%)
7-11 month gap	401 (1%)	1,002 (1%)	323 (1%)	172 (<1%)	95 (<1%)
12-16 month gap	19 (<1%)	80 (<1%)	33 (<1%)	7 (<1%)	7 (<1%)

Figure 32. Comparison of IowaCare and FMAP members with at least one switch and the months of gap during switch period by program, CY 2013

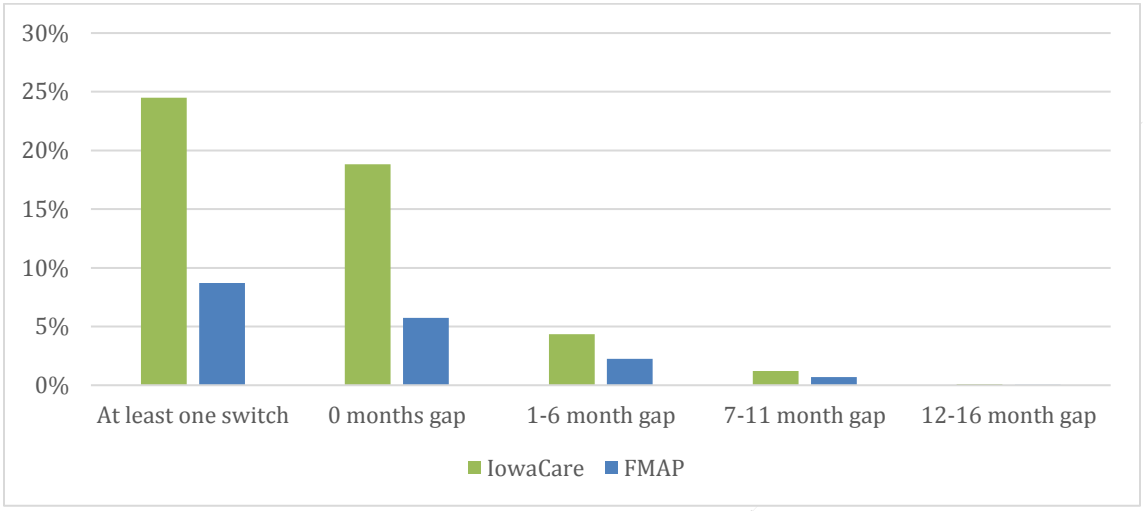
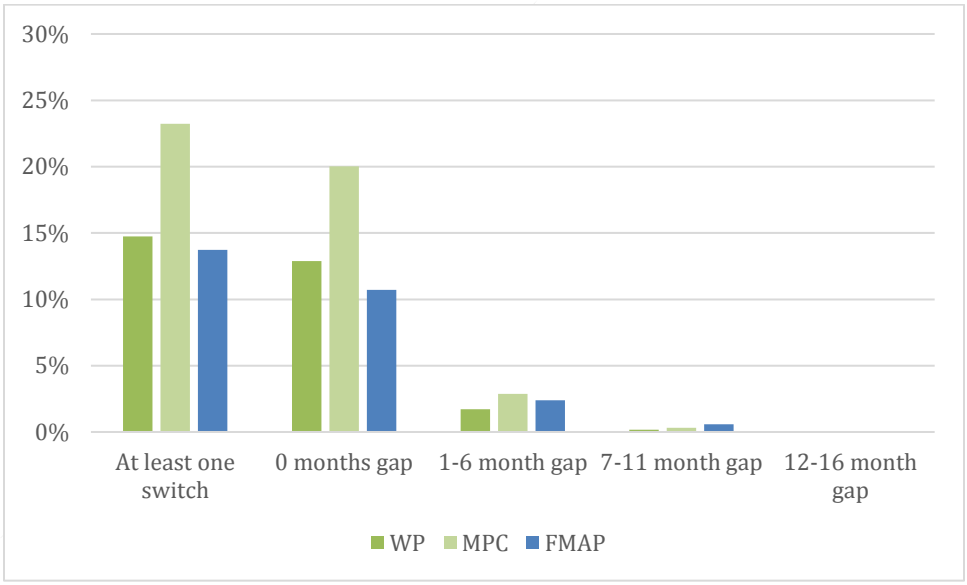


Figure 33. Comparison of WP, MPC, and FMAP members with at least one switch and the months of gap during switch period by program, CY 2014



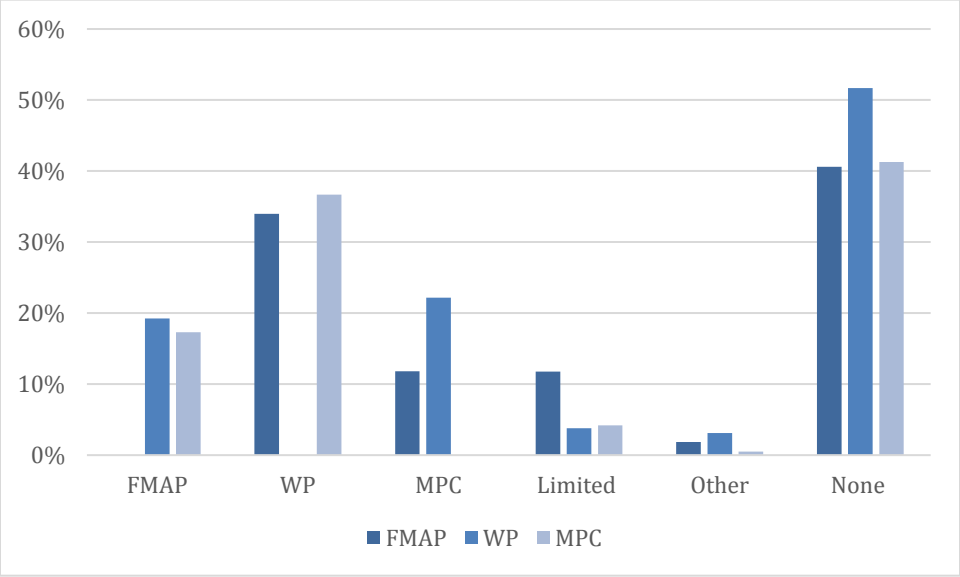
A primary reason for studying churn, particularly in the face of new programs, is to determine whether members who would have lost coverage are able to retain that coverage. Over 10,000 members lost their IowaCare coverage when that program was terminated and replaced with the IHAWP. Of these, 2,299 members were able to obtain coverage again during the year, leaving 7,743 with no coverage from a public insurance program. During CY 2014 the crucial question is what proportion of members who lost coverage in the FMAP were able to obtain coverage either in WP or MPC and what proportion of members who lost coverage in WP were able to obtain coverage in MPC. During CY 2014, 8,301 FMAP members, 19,634 WP members and 6,709 MPC members lost

coverage and did not obtain any additional months of coverage through Medicaid or IHAWP by April 2015. Additionally, there were 39,898 times when members had to switch out of a program. Of these, 17, 382 members switched 17, 778 times upward, moving from FMAP to either WP or MPC or moving from WP to MPC, **retaining** coverage when it would not have been possible without IHAWP. Additionally, 5,730 members moved from WP and MPC to FMAP or from MPC to WP 12,195 times. **Table 18** provides the raw number of members and the program they switched out of and the program they moved into. The proportion of members moving from program to program is shown in **Figure 34**. Some members moved into limited coverage programs which include the Family Planning Waiver, Medicaid for Employed People with Disabilities, and dual Medicare/Medicaid eligibility (Limited), while some members entered 'Other' programs which include specified waivers.

Table 18. FMAP, WP, and MPC member switches, CY 2014

Program member entered	Program member left		
	FMAP	WP	MPC
FMAP	0	7,431	2,733
WP	6,838	0	5,792
MPC	2,380	8,560	0
Limited	2,363	1,470	665
Other	376	1,212	78
Total	11,957	18,673	9,268

Figure 34. The proportion of members leaving FMAP, WP and MPC and the program they entered, CY 2014



'Positive churn', movement into another program as income increases, represents a success for programs aiming to increase health care coverage, while the complete loss of coverage may

represent a failure of the system to maintain coverage. Though members may leave the system for many reasons such as moving out of the state or obtaining employer-based health insurance, elopement may also indicate a loss of the physical, cognitive or emotional resources to maintain coverage. **Table 19** compares those who made a positive movement by maintaining coverage while their income increased to those who lost coverage and had not regained it by April 2015. The primary differences between the two groups are that those who experience positive churn are more likely to be white, more likely to be female, and older than those who lose coverage.

Table 19. Demographic characteristics of members with positive churn and members who lost coverage, CY 2014

	Positive churn N (%)	Lost coverage N (%)
Program		
FMAP	4,982 (29%)	8,301 (20%)
WP	8,251 (48%)	19,634 (46%)
MPC	524 (3%)	6,079 (14%)
All other programs	3,625 (21%)	8,314 (20%)
Gender		
Female	11,363 (65%)	22,208 (53%)
Male	6,019 (35%)	20,120 (47%)
Race		
White	11,343 (65%)	21,678 (51%)
Black	1,427 (8%)	3,623 (8%)
American Indian	195 (1%)	444 (1%)
Asian	406 (2%)	721 (2%)
Hispanic	640 (4%)	2,427 (6%)
Pacific Islander	125 (1%)	147 (1%)
Multiple-Hispanic	172 (1%)	470 (1%)
Multiple-Other	126 (1%)	231 (1%)
Undeclared	2,948 (17%)	12,587 (30%)
Age		
18-21 years	731 (4%)	3,528 (8%)
22-30 years	5,094 (29%)	13,741 (33%)
31-40 years	5,080 (29%)	10,780 (26%)
41-50 years	3,481 (20%)	7,280 (17%)
51 and over	2,996 (17%)	6,999 (17%)
County rural/urban status		
Metropolitan	10,553 (61%)	26,271 (62%)
Non-metropolitan, urban	752 (4%)	1,715 (4%)
Non-metropolitan, rural	6,077 (35%)	14,342 (34%)
Total	**17,382**	**42,328**

Hypothesis 2.2

Iowa Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.

Measure 28 Proportion who had to change primary care physician when joining the Wellness Plan or Marketplace Choice

Measure 29 Continuity of care and satisfaction if they need to change to a new primary care physician when enrolled with a new plan

Definition

Continuity of care was measured by assessing through the survey whether or not the respondent changed personal doctor after enrolling in their new health plan and ease in changing primary care provider if they chose to do so. The following measures were used:

1. Continuity in personal doctor = Percentage who respond that their currently identified personal doctor is the same person who was their personal doctor before enrolling in the new health plan.
2. Choice to change primary care provider = Percentage who responded that they decided to change primary care providers from the one they were assigned.
3. Ease of change = Percentage who reported that it was 'Somewhat easy' or 'Very easy' to change from their assigned primary care provider.

It should be noted that measure (1) was only assessed for those who identified that they had someone they considered to be their personal doctor. Measure (2) was only assessed for those who identified that they were automatically assigned a primary care provider and measure (3) was only assessed for those who decided to change to a new primary care provider from the one they were assigned.

With regard to continuity with a personal doctor (measure 1), several questions were asked only of IHAWP members. For those with a personal doctor, members were asked "Is your personal doctor the same person who was your personal doctor before you enrolled in your new health plan?" Response options included: Yes, I have the same personal doctor; No, I have a different personal doctor; and I did not have a personal doctor before enrolling in [the IHAWP].

Results

Figure 35 describes continuity of care with providers for IHAWP members. With regard to continuity with a personal doctor (i.e., remaining with the same personal doctor after enrollment in the IHAWP), significantly more MPC members (64%) than WP members (43%) reported having the same personal doctor as before enrolling in the IHAWP ($p<.0001$). However, significantly more WP members (20%) compared to MPC members (13%) reported having a personal doctor after IHAWP enrollment when they did not have one before ($p=.002$).

As part of the IHAWP enrollment process, members may have been automatically assigned to a primary care provider (PCP) and were given the option to change to a different provider from the one to which they were assigned. Significantly more WP members (57%) than MPC members (30%) reported being automatically assigned to a PCP ($p<.0001$). And, of those who were auto-assigned to a PCP, significantly more WP members (41%) than MPC members (28%) decided to change to a different PCP ($p=.01$) with around two-thirds of the members reporting that it was 'very easy' to change from their assigned PCP to a different one (67% WP, 67% MPC).

Measure 30 Regular source of care – Personal Doctor

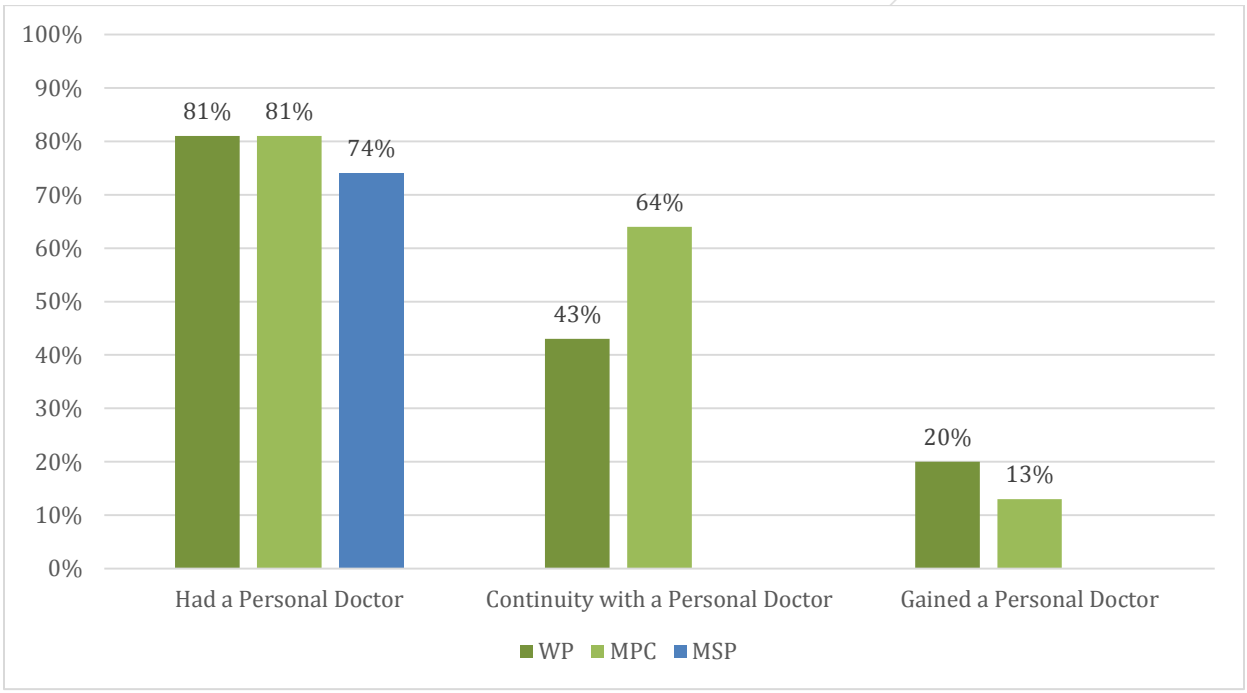
Definition

The surveys included the following item that was used to assess regular source of care: "Do you have a personal doctor [A personal doctor is the person you would see if you need a check-up, want advice about a health problem, or get sick or hurt.]?" Regular source of care was defined as the percentage who responded that they currently had a personal doctor.

Results

Figure 35 describes member experiences with having a regular source of care and continuity with that care. The majority of members reported having a regular source of care (MSP: 81%, WP: 81%, MPC: 74%). Significantly fewer MPC members reported a usual source of care when compared to MSP.

Figure 35. Having a Personal Doctor and Continuity of Care



Quality of Care

Question 3 *What are the effects of the Iowa Wellness Plan on member quality of care?*

Hypothesis 3.1

Iowa Wellness Plan members will have equal or better quality of care.

Measure 31 Avoidance of antibiotic treatment in adults with acute bronchitis

Removed due to difficulty with measure definition.

Measure 32 Use of appropriate medications for people with asthma

Removed due to removal from HEDIS measure set.

Measure 33 Medication management for people with asthma

Removed due to recent articles indicating this measure is not reflective of later outcomes.

Measure 34 Pharmacotherapy management of COPD exacerbation (Measures 34A and 34B)

Removed due to an inability to determine whether hospitalization was for exacerbation of COPD.

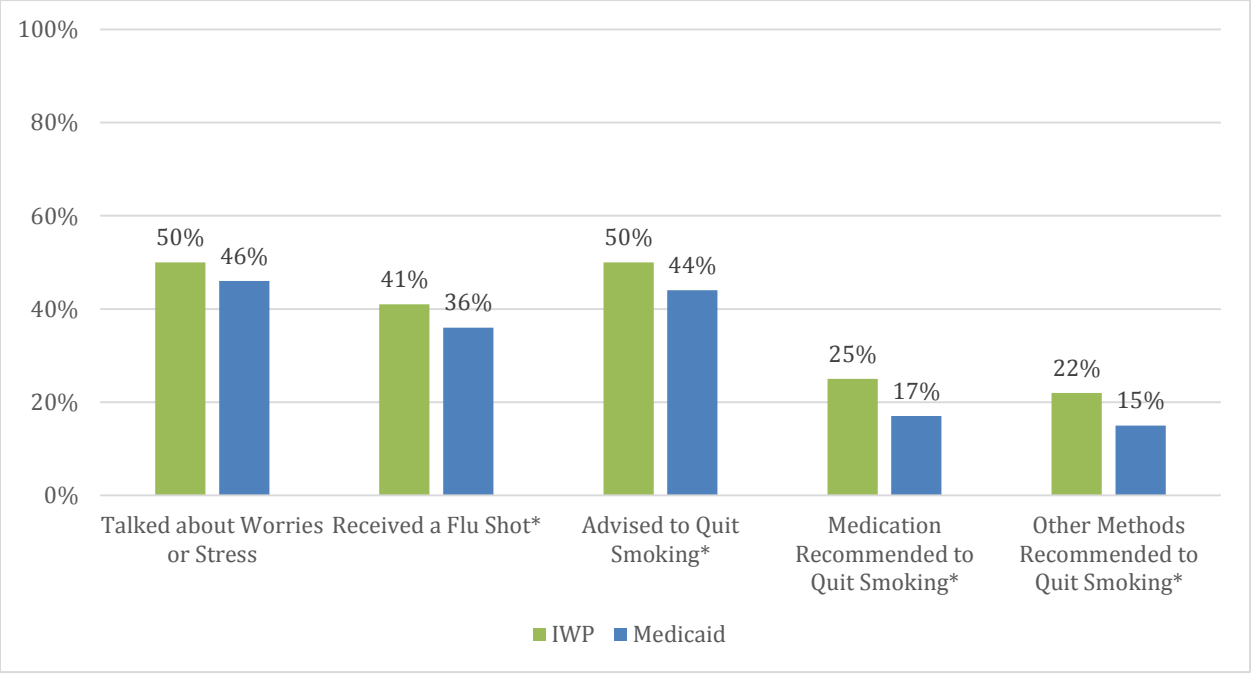
Measure 35 Cholesterol management for patients with cardiovascular conditions (Measures 35A and 35B)

Removed due to small numbers.

Measure 36 Self-reported receipt of flu shot

Significantly greater proportion of IWP members (41%) compared to Medicaid members (36%) reported receiving a flu shot.

Figure 36. Self-reported preventive activities at the office visit



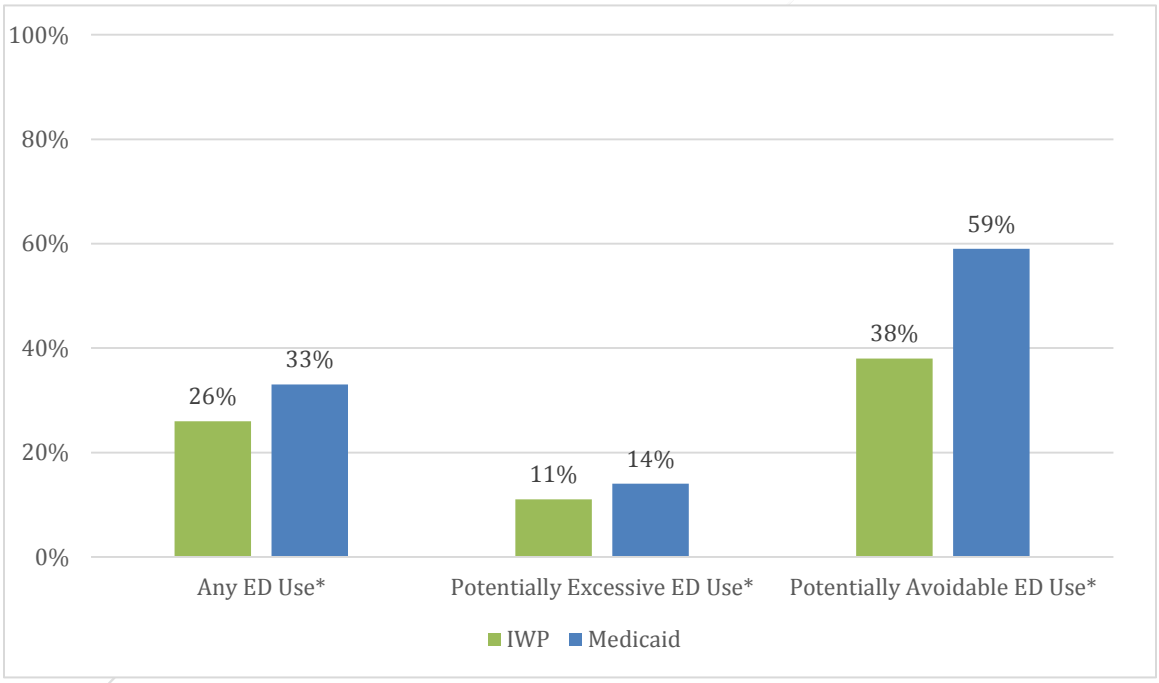
* Statistically significant difference at p<.05

Measure 37 Emergency department use

There were several questions in the survey that tried to assess "appropriate" emergency department (ED) use. In addition to reporting any ED use, we defined potentially "excessive" ED use if the respondent reported using the ED two or more times in the previous six months. The surveys included a question asking those with at least one ED visit if the care from their most recent ED visit could have been provided in a doctor's office if one was available at the time. Affirmative responses to that question defined potentially "avoidable" ED use.

Figure 37 provides the ED experiences of IWP and Medicaid members. One-third of Medicaid members (33%) and around one-quarter (26%) of IWP members used the ED at least once in the six month period, and that difference was significant. Significantly fewer IWP members (11%) than Medicaid members (14%) reported two or more visits to the ED in a six month period. Also, significantly fewer IWP members (38%) compared to Medicaid members (59%) reported that the care at their last visit to the ED could have been provided in a doctor's office. There were no significant differences by MCO with regard to emergency department use for IWP members.

Figure 37. Emergency Department Use by IWP and Medicaid Members



* Statistically significant difference at p<.05

As a follow-up to the assessment of potentially avoidable ED use, IWP and Medicaid members were asked about barriers to their ability to go to a doctor's office instead of the ED for their health care (**Table 20**). A little less than half of IWP (40%) and Medicaid (45%) members reported using the ED instead of the doctor's office or clinic because the doctor's office or clinic was not open when they needed care. Over one in five (IWP 27%, Medicaid 23%) reported that their health problem was too serious for the doctor's office (i.e., they needed to use the ED). A healthcare provider advised ED use for 13% of IWP and 10% of Medicaid members and inability to get an appointment at the doctor's office was reported by 6% of IWP and 11% of MPC members.

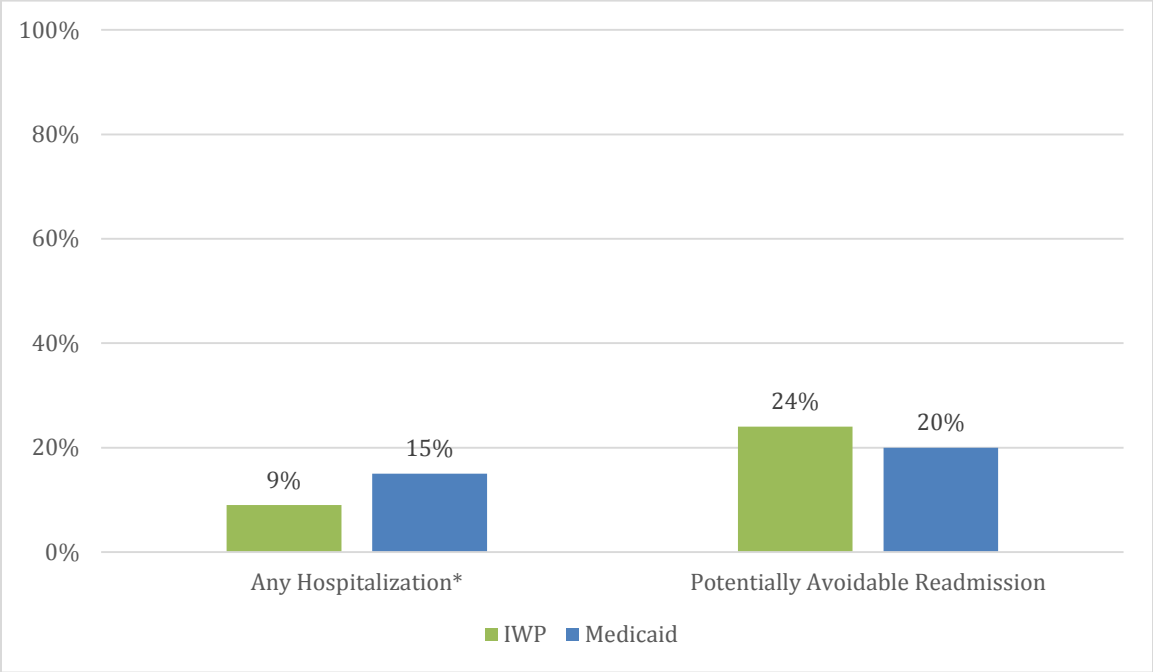
Table 20. Barriers to Going to a Doctor's Office Instead of the ER for Health Care

IWP (n=420)	Medicaid (n=278)	Response Options
40%	45%	A doctor's office or clinic was not open when I needed care
27%	23%	Health problem was too serious for the doctor's office
13%	10%	Healthcare provider told them to go to the ER for care
6%	11%	Could not get an appointment with the doctor's office or clinic
7%	6%	Did not have a doctor or clinic to go to
3%	2%	I had transportation problems getting to a doctor's office or clinic

The results of two questions asking about hospital stays are summarized in **Figure 38**. The first asked how many nights the respondent spent in the hospital for any reason in the six months prior to the survey. The second was used to get a sense of potentially "avoidable" readmissions to the hospital and asked respondents who had reported a hospitalization if they ever had to go back into the hospital within 30 days of being allowed to go home because they were still sick or had a problem.

Significantly fewer IWP members (9%) than Medicaid members (15%) reported any hospital stays in the six month period. However, there were no significant differences between IWP and Medicaid members with regard to recent readmissions. And there were no significant differences in reported hospitalization and readmission by MCO for IWP members.

Figure 38. Hospitalization and Readmission by IWP and Medicaid Members



* Statistically significant difference at p<.05

Hypothesis 3.2

Iowa Wellness Plan members will have equal or lower rates of hospital admissions.

Measure 38 Admission rate for COPD, diabetes short-term complications, CHF, and asthma

Removed due to lack of admissions for diabetes short-term complications.

Measure 39 Admission rate for COPD

Definition

The Prevention Quality Indicators (PQI) include the number of discharges for COPD and asthma per 100,000 Medicaid members. We utilized the AHRQ WinQI calculator to identify the hospitalizations reflecting COPD/asthma admission. The number of admissions was then calculated as number of admissions per 100,000 members who were enrolled for at least 11 months of the year. The rates are reported for CY 2016 and CY 2017 only, as the change in diagnosis coding from ICD-9 to ICD-10 resulted in a new AHRQ WinQI calculator for CY 2016.

Results

Rates of admission for COPD/asthma were much higher for IWP than for FMAP in both years with the rate of admission being nearly three times higher for IWP than for FMAP members (**Table 21**). This may be expected due to the increased age of IWP members and the higher likelihood of chronic conditions in this group.

Table 21. COPD/asthma admission rate for members 19-64 years of age CY 2016 – CY 2017

	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Members	26,411	100,377	37,589	115,867
Number of admissions	16	178	14	183
Admission rate/100,000	61	177	37	158

Measure 40 Admission rate for diabetes short-term complications (Measures 40A and 40B)

Removed due to lack of admissions for diabetes short-term complications.

Measure 41 Admission rate for CHF (Measures 41A and 41B)

Definition

The Prevention Quality Indicators (PQI) include the number of discharges for CHF per 100,000 Medicaid members. We utilized the AHRQ WinQI calculator to identify the hospitalizations reflecting CHF admission. The number of admissions was then calculated as the number of admissions per 100,000 members who were enrolled for at least 11 months of the year.

Results

Rates of admission for CHF were much higher for IWP than for FMAP in both years (**Table 22**). This might be expected as the FMAP population is younger than the IWP population and much less likely to be experiencing chronic diseases such as CHF.

Table 22. CHF admission rate for members 19-64 years of age CY 2016 – CY 2017

	FMAP 2016	IWP 2016	FMAP 2017	IWP 2017
Members	26,411	100,377	37,589	115,867
Number of admissions	23	163	29	195
Admission rate/100,000	87	162	77	168

Measure 42 Avoidance of antibiotic treatment in adults with acute bronchitis

Removed from the evaluation in consultation with CMS.

Measure 43 Inpatient utilization-general hospital/acute care

Removed from the evaluation.

Measure 44 Plan "all cause" hospital readmissions

Removed as current HEDIS measures do not allow for risk adjustment.

Measure 45 Rate of hospital admissions in past 6 months

See results under Measure 37.

Measure 46 Rate of 30 day hospital readmissions

See results under Measure 37.

Hypothesis 3.3

Iowa Wellness Plan members will report equal or greater satisfaction with the care provided.

Measures 47 through 50 provide an assessment of member experiences with their providers during office visits. Figure 21 provides the percentages by group for each of these measures.

Measure 47 Provider communication

Communication between providers and patients was assessed using a four-item composite measure comprised of the following questions:

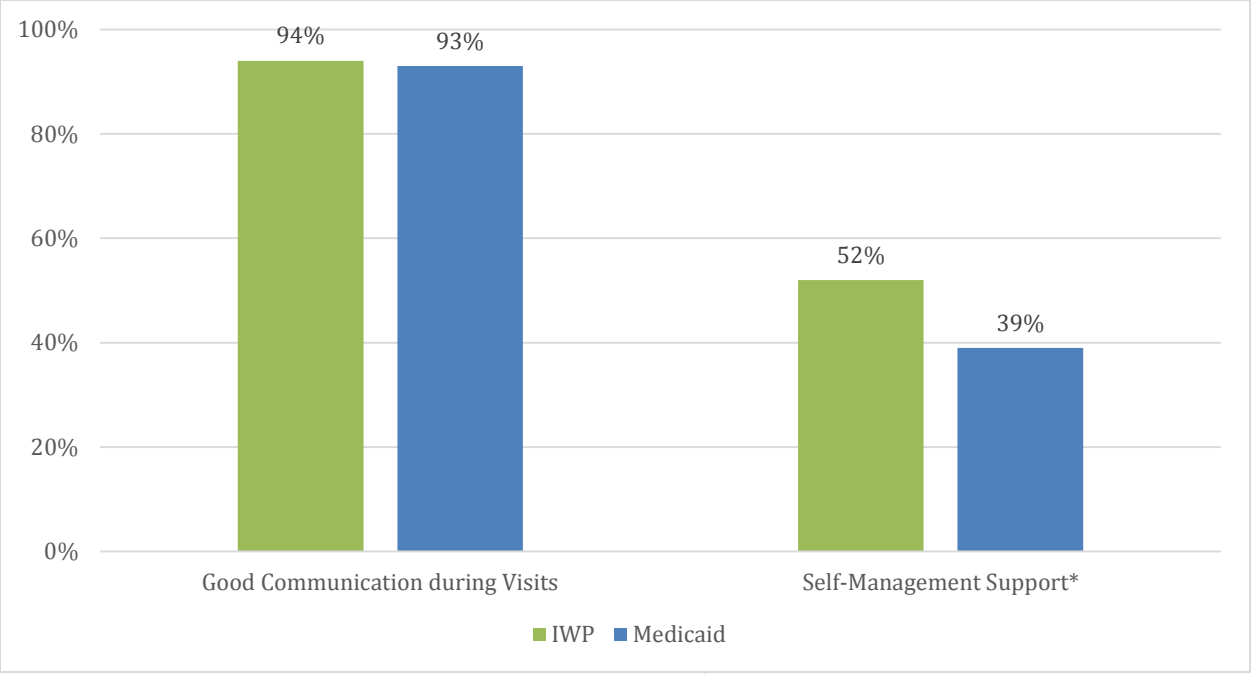
- How often did your personal doctor explain things in a way that was easy to understand?
- How often did your personal doctor listen carefully to you?
- How often did your personal doctor show respect for what you had to say?
- How often did your personal doctor spend enough time with you?

Self-Management Support was assessed using a two-item composite measure comprised of the following questions:

- Did anyone in a doctor's office talk with you about specific goals for your health?
- Did anyone in a doctor's office ask you if there are things that make it hard for you to take care of your health?

Figure 39 provides a summary of the findings for IWP and Medicaid member experiences with communication with their provider and receipt of self-management support. The vast majority of IWP (94%) and Medicaid members (93%) reported good communication ('usually' or 'always' communicated well) with their provider during their office visits. Significantly more IWP members (52%) compared to Medicaid members (39%) reported receiving self-management support from their provider. Within IWP, there were no significant differences by MCO with regard to communication and self-management support.

Figure 39. IWP and Medicaid Member Experiences with Communication and Self-Management Support



* Statistically significant difference at p<.05

Measure 48 Self-management support

See results under Measure 47.

Measure 49 Attention to mental/emotional health (Comprehensive care)

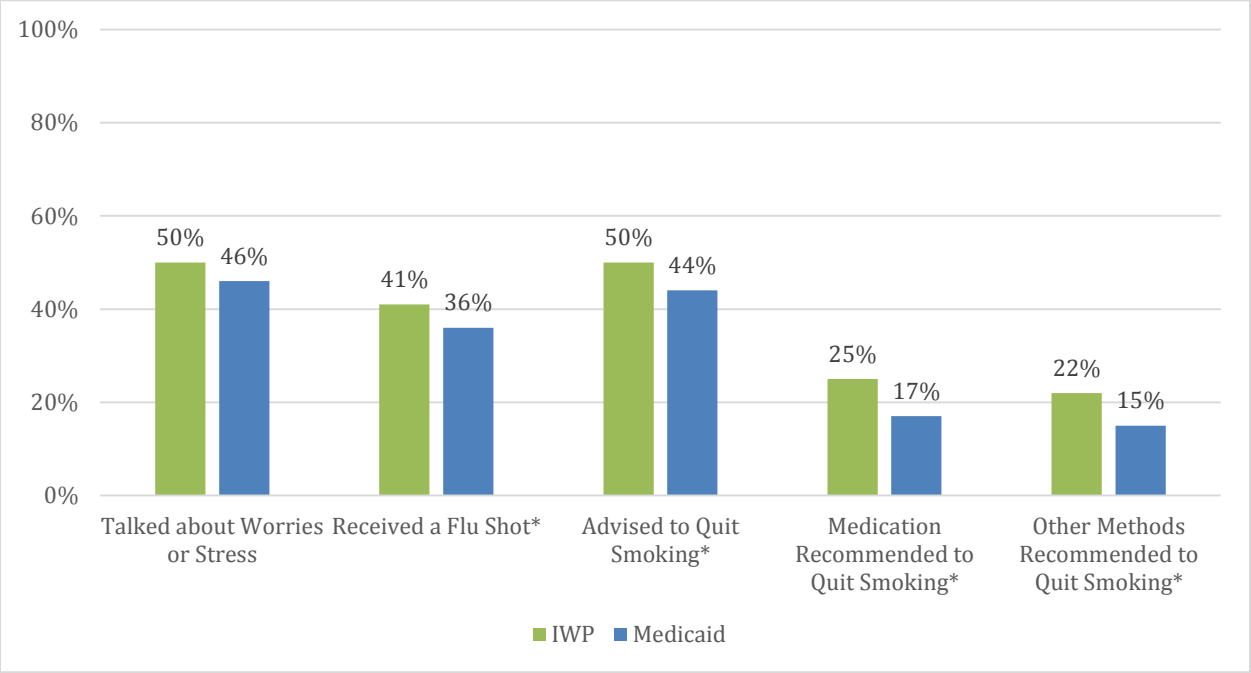
Comprehensiveness of Care was assessed using the following items:

- Did you and anyone in a doctor's office talk about things in your life that worry you or cause you stress?
- Have you had a flu shot since September 1, 2016?
- For smokers, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?
- For smokers, how often was medication (such as nicotine gum, patch, nasal spray, inhaler, or prescription medicine) recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco?
- For smokers, how often did your doctor or health provider discuss or provide methods and strategies other than medication (such as telephone hotline, individual or group counseling, or a cessation program) to assist you with quitting smoking or using tobacco?

Figure 40 provides a summary of the findings for IWP and Medicaid member comprehensive care experiences. Around one-half of IWP and Medicaid members reported talking with someone from

their doctor's office about things in life that worried them or caused them stress. Significantly more IWP members (41%) compared to Medicaid members (36%) received a seasonal flu shot. As reported earlier, around 40% of IWP members and 38% of Medicaid members reported smoking cigarettes or using tobacco at least some days. Of these, significantly more IWP members than Medicaid members reported being advised to quit smoking and were recommended ways to quit. Within IWP, there were no differences by MCO with regard to these concepts.

Figure 40. IWP and Medicaid Member Experiences with Comprehensive Care



* Statistically significant difference at p<.05

Measure 50 Shared decision-making regarding medications

Definition

Shared decision-making regarding prescription medications was assessed using a three-item composite measure comprised of the following questions:

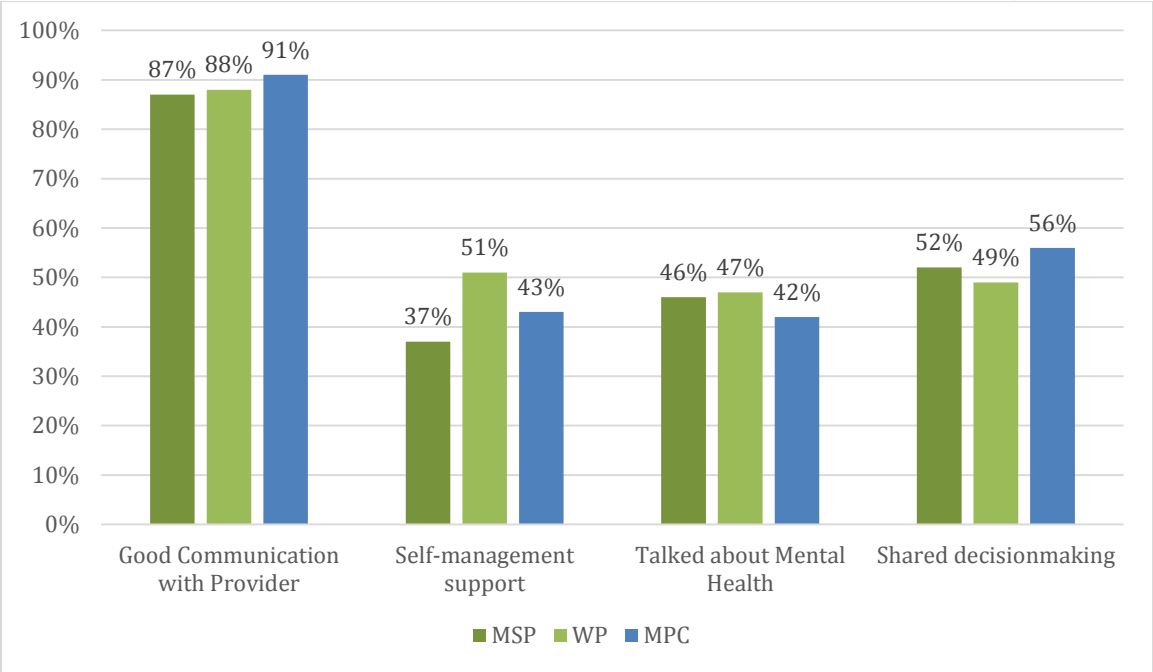
1. When you talked about starting or stopping a prescription medicine, how much did the doctor or other health provider talk about the reasons you might want to take a medicine?
2. When you talked about starting or stopping a prescription medicine, how much did the doctor or other health provider talk about the reasons you might not want to take a medicine?
3. When you talked about starting or stopping a prescription medicine, did the doctor or other provider ask you what you thought was best for you?

A composite measure defined by CAHPS and incorporating these three items was used to provide a summary measure of member satisfaction with how well providers shared decision making with them about prescription medications use.

Results

Figure 41 below provides the results of this analysis. Around half of the members from each group (52% of MSP members, 49% of WP members, and 56% of MPC members) reported that their provider shared decision making with them regarding prescription medications.

Figure 41. Member Experiences during Office Visits



Measure 51 Care coordination

To assess timely access to care, we used a three-item composite measure comprised of the following questions:

- When you needed care right away, how often did you get care as soon as you needed?
- How often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
- When you phoned a doctor's office during regular office hours, how often did you get an answer to your medical question that same day?

Access to after-hours care was assessed using one item that asked about whether or not the provider gave them information about how to access care after hours:

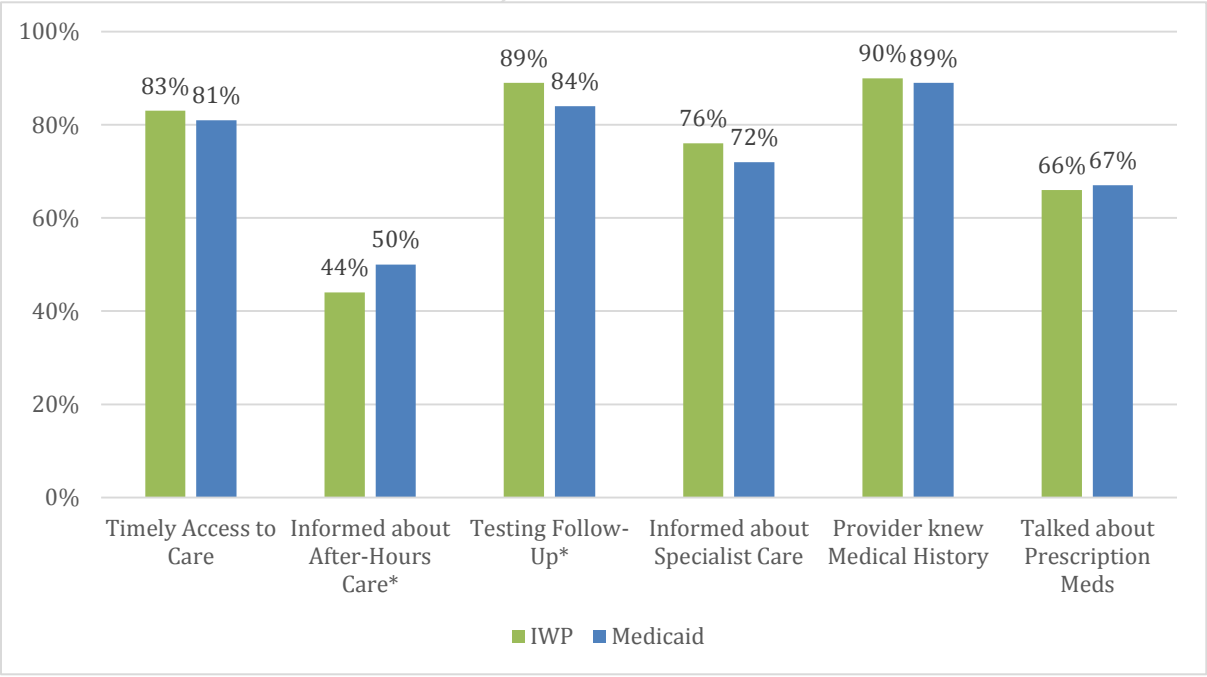
- Did a doctor's office give you information about what to do if you needed care during evenings, weekends, or holidays?

Care Coordination was assessed using four items related to different aspects of providing care coordination:

- When your doctor's office ordered a blood test, x-ray, or other test for you, how often did someone from the doctor's office follow up to give you those results?
- How often did your personal doctor's office seem informed and up-to-date about the care you got from specialists?
- How often did your personal doctor seem to know the important information about your medical history?
- How often did you talk with someone from your doctor's office about all the prescription medicines you were taking?

Figure 42 provides a summary of the findings with regard to members' experiences with their doctor's office. IWP and Medicaid members' experiences were similar with regard to timely access to care (83% IWP, 81% Medicaid), having a provider informed about specialist care (76% IWP, 72% Medicaid), having a provider who knew their medical history (IWP 90%, Medicaid 89%), and having talked about their prescription medicines (IWP 66%, Medicaid 67%). Yet, significantly more IWP members (89%) than Medicaid members (84%) reported that their doctor's office followed up with them to give them results of testing. And, around 50% of Medicaid members reported receiving information from their doctor's office about what to do if they needed care after-hours which was significantly higher than reported by IWP members (44%). Within IWP, there were no significant differences by MCO with regard to member experiences with their doctor's office.

Figure 42. IWP and Medicaid Member Experiences with their Doctor's Office



* Statistically significant difference at p<.05

Measure 52 Rating of personal doctor

Respondents were asked to rate various aspects of the health care they received and also their health plan on a 0 to 10 scale, where 0 was defined as the worst possible and 10 as the best possible. Ratings were obtained for the following:

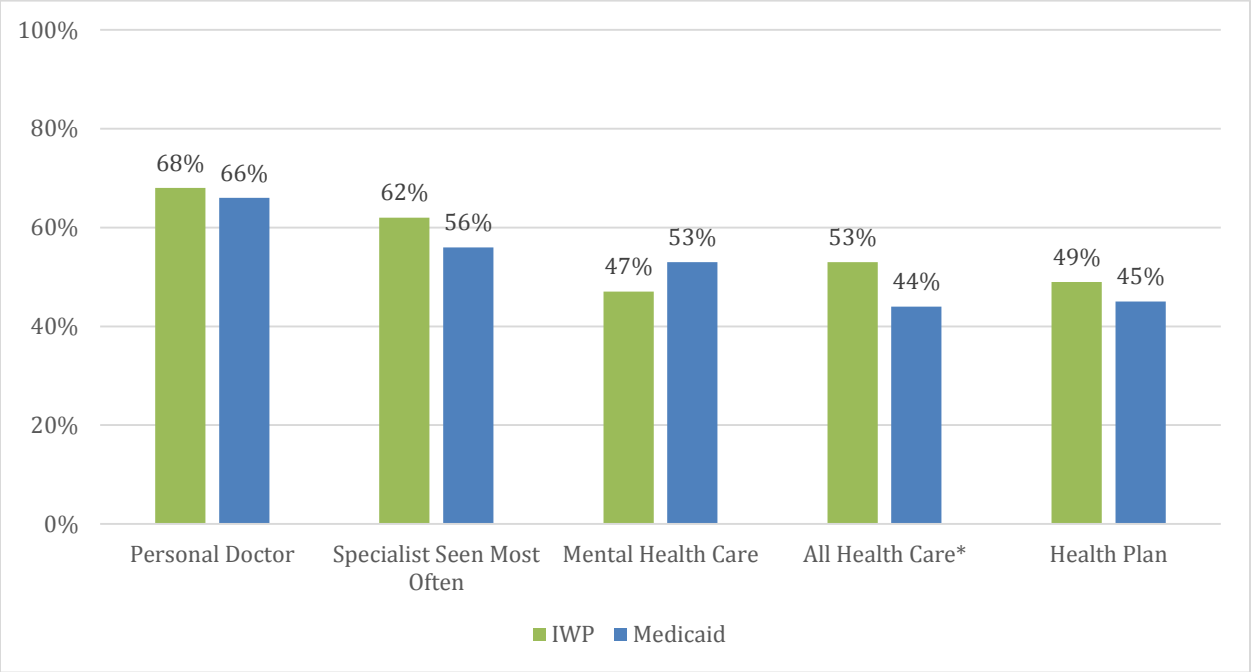
- Personal Doctor
- Most Often Seen Specialist
- Mental Health Treatment or Counseling
- All Health Care Received
- Health Plan

Figure 43 provides a summary of the percentage of respondents who rated each of these areas as a '9' or '10' which indicates the highest possible ratings. Around two-thirds of respondents rated their personal doctor as a '9' or '10' and there was no significant difference between IWP (68%) and Medicaid (66%). There were no statistically significant differences between IWP and Medicaid members in their ratings of specialist care, mental health care, or health plan. However, significantly more IWP members (53%) than Medicaid members (44%) rated their overall health care highly. The CAHPS online reporting system contains National Comparative Data[4] (NCD) for each of these rating measures with the exception of mental health care. IWP and Medicaid members' ratings of their personal doctor and their overall health care are similar to the NCD (NCD: 65% personal doctor; 53% overall health care) but are somewhat lower than reported in the NCD for specialist care (NCD, 65%) and health plan (NCD, 57%).

For IWP members, there were no significant differences by MCO with regard to ratings of their providers, health care, and health plan.

[4] Formerly known as National CAHPS Benchmarking Database (NCBD). More information available at https://cahpsdatabase.ahrq.gov/cahpsidb/

Figure 43. High Ratings of Care and Health Plan Quality for IWP and Medicaid



* Statistically significant difference at p<.05

Measure 53 Rating of all health care received

See results under Measure 52.

Measure 54 Rating of health care plan

See results under Measure 52.

Cost

Question 4 *What are the effects of the Iowa Wellness Plan on the costs of providing care?*

Hypothesis 4.1

The cost for covering Iowa Wellness Plan members will be comparable to the predicted costs for covering the same expansion group in the Medicaid State Plan.

Measure 55 Compare Iowa Wellness Plan PMPM costs to those in the Medicaid State Plan

Costs analyses were removed for the current waiver period as a capitated payment mechanism was introduced. Previous results indicated that costs for IWP members were lower than costs for adult members in Medicaid State Plan.

Premiums and Cost Sharing

Question 5 *What are the effects of the premium incentive and copayment disincentive programs on Iowa Wellness Plan enrollees?*

Hypothesis 5.1

The premium incentive for the Iowa Wellness Plan enrollees will not impact the ability to receive health care.

Measure 56 Awareness of Premium Incentive

By getting a wellness exam (either a medical check-up or a dental check-up) and completing an HRA, IWP members would avoid having to pay a monthly premium for their health care in the following year of the program. In the survey, IWP members were given the following information about the incentives to avoid paying a monthly premium:

"As part of your health plan from your MCO, you are supposed to get a medical or dental check-up and complete a health risk assessment (a survey that asks questions about your health). If you do not, you may have to pay a monthly premium/fee (depending on your income) in the following year."

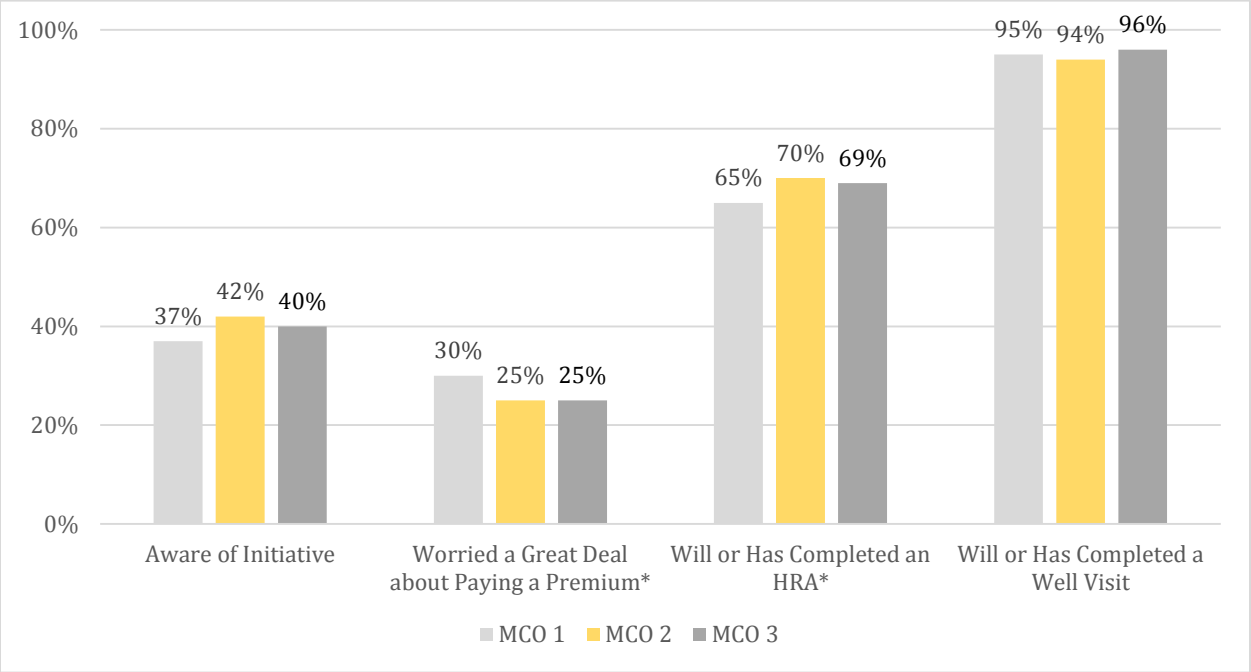
Members were then asked the following:

- Did you know you may have to pay a monthly premium (fee) next year if you do not get a medical or dental check-up and complete a health risk assessment this year? [Awareness of initiative]
- Do you think you will complete a health risk assessment this year? [Willingness to participate]
- Do you think you will get a medical or dental check-up this year? [Willingness to participate]
- Do you think any of the following would keep you from getting a medical check-up this year? [Barriers to complying]
- Do you think any of the following would keep you from getting a dental check-up this year? [Barriers to complying]
- How much would it worry you if you had to pay a premium (a $5 or $10 fee) every month for your health plan? [Hardship for non-compliance]

Figure 44. Healthy Behaviors Program Premium Avoidance Incentives within IWP provides a summary of the findings related to the HBP premium avoidance incentives. Overall, around 40% of IWP members were aware that they would have to pay a premium if they did not get a medical or dental check-up and complete an HRA in the year of their enrollment (37%-42% across all three MCOs).

Around 70% of IWP members either had already completed or were intending to complete an HRA; around 25% reported not knowing what an HRA was. The vast majority of IWP members, regardless of MCO enrollment (94%-96%), reported either having already obtained a medical or dental check-up or intent to get one.

Figure 44. Healthy Behaviors Program Premium Avoidance Incentives within IWP



* Statistically significant difference at p<.05

Measure 57 Member Perception of Ease of Obtaining Annual Physical Exam

Table 23 provides a summary of the barriers to obtaining a medical check-up reported by IWP members. Around 40% of IWP members reported that they had already obtained a medical check-up. Around 8% reported that they did not think they needed a medical check-up.

Table 23. Barriers to Obtaining a Medical Check-Up

MCO 1	MCO 2	MCO 3	Response options
6%	8%	10%	I don't believe I need a medical check-up
6%	6%	6%	I am not sure where to go to get a medical check-up
7%	5%	6%	I don't currently have a doctor
4%	8%	5%	I don't like getting a medical check-up
5%	4%	3%	Getting transportation to my doctor's office is hard
5%	4%	3%	I can't get the time off of work/can't get child care
3%	1%	3%	It is hard to get an appointment for a medical check-up from my doctor
2%	2%	2%	I don't like my current doctor

Table 24 provides a summary of the barriers to obtaining a dental check-up reported by IWP members. Around 28% of IWP members reported that they had already obtained a dental check-up. Access to a dentist was a common reason reported by IWP members for not being able to get a dental check-up. Regardless of MCO type, the most commonly reported barrier to obtaining a dental check-up was current lack of having a dentist. Around 12% reported not being sure about where to go to get a dental check-up.

Table 24. Barriers to Obtaining a Dental Check-Up

MCO 1	MCO 2	MCO 3	Response options
17%	17%	19%	I don't currently have a dentist
13%	11%	12%	I am not sure where to go to get a dental check-up
8%	8%	7%	I don't like getting a dental check-up
4%	5%	7%	I don't believe I need a dental check-up
6%	4%	3%	Getting transportation to my doctor's office is hard
4%	4%	3%	It is hard to get an appointment for a dental check-up from my dentist
4%	2%	3%	I can't get time off from work/can't get check care
1%	1%	2%	I don't like my current dentist

Measure 58 Member Perception of Hardship of Premium Levels

See results under Measure 57.

Measure 59 Ability to receive services for those who are disenrolled due to the lack of a premium payment in year two and three

See results under Hypothesis 5.2.

Hypothesis 5.2

The majority of IWP members will complete the healthy behaviors and therefore not have to pay a premium incentive or be disenrolled.

Disenrollment was studied for the first waiver period. The results can be found in the following report http://ppc.uiowa.edu/publications/healthy-behaviors-dis-enrollment-interviews-report-depth-interviews-iowa-health-and

Measure 60 Completion of healthy behaviors in the specified time period without a monthly premium

Proportion of members who complete the healthy behaviors prior to the application of the premium payment

Measure 61 Completion of healthy behaviors only after paying a monthly premium

Proportion of members who complete the healthy behaviors only after the application of the premium payment

Measure 62 Disenrollment as a result of not completing the healthy behaviors or not paying the monthly premiums

Proportion of members who are disenrolled due to the application of a premium payment as a result of not completing the healthy behaviors

Hypothesis 5.3

The copayment for inappropriate emergency department (ED) use for the Iowa Wellness Plan enrollees will not pose an access to care barrier.

Measure 63 Awareness of the copayment

Another behavior change initiative within the IWP involves the appropriate use of ED services. As part of the IWP coverage, members may have to pay an $8 copayment each time they use an ED for a non-emergent condition. The implementation of this requirement (copayment for non-emergent use of the ED) was delayed until late in 2016.

In the IWP survey, we were able to assess members' knowledge and potential impact of the copayment for non-emergent ED use. IWP members were given the following information about the fee for non-emergent use of the ED:

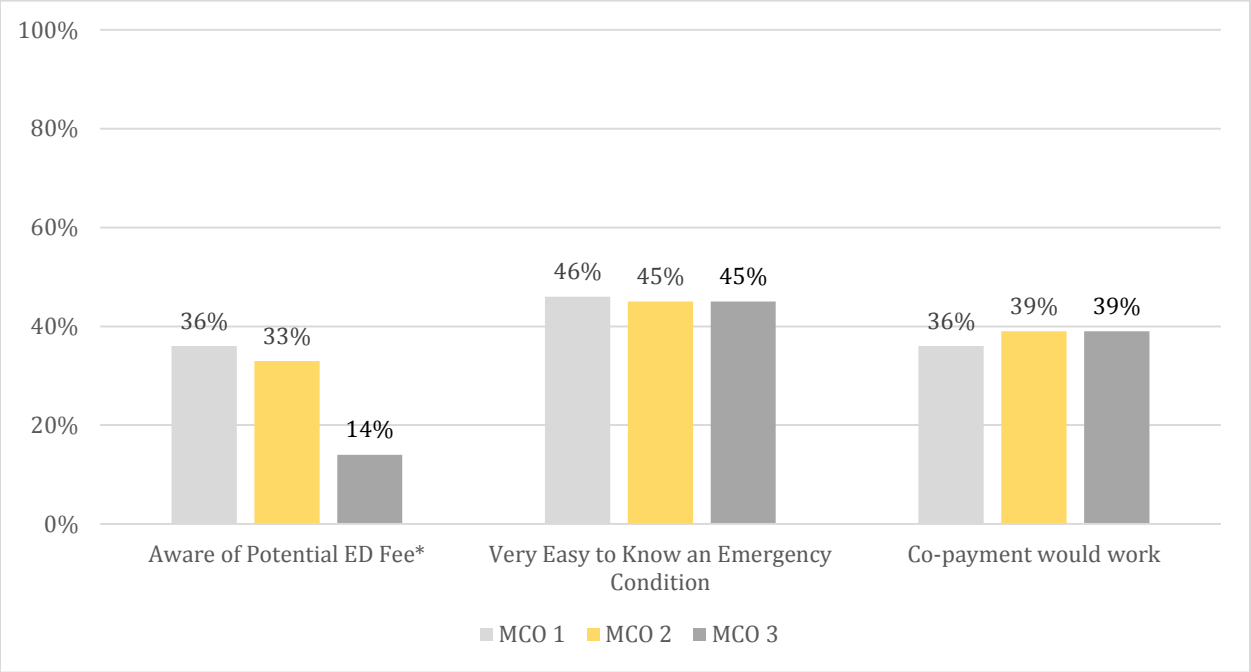
"As part of your health plan from your MCO, after you have been enrolled for one year, you may have to pay $8.00 each time you use an emergency room for a non-emergency condition. An emergency is considered to be any condition that could endanger your life or cause permanent disability if not treated immediately."

They were then asked the following:

- Did you know that you may have to pay an $8 fee anytime you use the emergency room when your health condition is not an emergency, beginning one year after you started in this program? [Awareness of initiative]
- How easy do you think it would be to know when your health condition would be considered an emergency? [Ease of complying]
- Do you think having to pay an $8 fee would keep you from going to the emergency room when you have a health condition that could be treated in your doctor's office instead? [Effectiveness of fee]

Figure 45 provides a summary of the findings related to the non-emergent ED use co-payment. While around one-third of MCO 1 (36%) and MCO 2 (33%) enrollees reported being aware of the ED use co-payment, significantly fewer MCO 3 enrollees (14%) reported awareness of the co-payment potential. Survey results from 2014-15 noted that only around 10% of members knew about the potential ED co-payment. Around 45% of IWP members, regardless of MCO enrollment, reported that it would be 'very easy' and around 3% reported that it would be 'very hard' to know when a health condition would be considered an emergency. And, around 40% reported that an $8 co-payment would keep them from going to the ED for a health condition that could have been treated in a doctor's office instead.

Figure 45. Non-Emergent ED Use Disincentives within IWP



* Statistically significant difference at p<.05

Measure 64 Awareness of non-emergent condition

See results under Measure 59.

Measure 65 Copayment as a disincentive

See results under Measure 59.

Provider Network Adequacy

Question 6 *What is the adequacy of the provider network for Iowa Wellness Plan enrollees as compared to those in the Iowa Medicaid State Plan?*

Hypothesis 6.1

Iowa Wellness Plan members will have the same access to an adequate provider network as members in the Medicaid State Plan.

Measure 66 Geographic distance and time spent travelling to primary care provider

Analyses of provider network adequacy were completed and contained in a June 2015 report entitled 'Evaluation of Provider Adequacy in the Iowa Health and Wellness Plan during the First Year', found at http://ppc.uiowa.edu/publications/evaluation-provider-adequacy-iowa-health-and-wellness-plan-during-first-year .

This report indicates that Iowa Wellness Plan members have the same access to an adequate provider network during the first waver period. This hypothesis was removed during the most recent waiver period as the adoption of statewide Medicaid Managed Care utilizing Managed Care Organizations to provide services to all Medicaid and IWP members brought the provider networks for both groups into alignment.

Measure 67 Analysis of rules and procedures for determining the adequacy of the provider network

Removed from evaluation due to difficulty in obtaining QHP documentation.

Measure 68 Provider willingness to accept new patients

See results under Measure 66.

Measure 69 Provider satisfaction with plan key components such as fee schedules and documentation

Removed from evaluation.

Measure 70 Comparison of network overlap between plans

Removed from evaluation due to difficulty of obtaining accurate, clean provider data from QHPs.

Measure 71 (MARKETPLACE CHOICE only) Provider network inclusion of safety net providers.

See results under Measure 66.

Limitations

As with all evaluations, there are limitations to the interpretation of these. Survey data, for example, are based on self-reported information and the recall of the member. Response bias is also a potential threat to validity. Non-response bias tests were conducted to determine if the characteristics of respondents differed significantly from non-respondents. Administrative data are collected for billing and tracking purposes and do not always reflect the service provided accurately.

There may be a propensity for members who have the most to gain from coverage to have accessed services earlier through the IowaCare program than those with less to gain. This has the potential to bias all the estimates of program effects on quality measures and costs. Essentially, those who are sicker may use services earlier and the reduction in costs accounted for these enrollees by the Wellness Plan may be greater than for later enrollees. Risk adjustments attempt to correct for this potential bias. Some methods, such as RDD, may result in estimates that are more valid but only pertain to a segment of the population (e.g., the beneficiaries around the income threshold between programs).

Though we proposed specific analytical tools within this evaluation document and even went so far as to link analytical strategies to hypotheses, we have had to change the methods and approaches for some measures due to small numbers, difficulty identifying the relevant populations, or unanticipated complexity in the measure design. We are still investigating the use of propensity scoring, instrumental variables analysis, and survival analysis as possible techniques. We have encountered difficulty obtaining some of the data required for the analyses such as the pharmaceutical data for the QHPs. In addition, we have found it much more difficult and laborious to integrate the new data formats and fields with our existing data repository hindering our ability to complete some of the administrative data based outcomes for the interim report. We continue efforts to clean and assimilate data more quickly.

Areas of emphasis

To clarify the areas of the evaluation designed to determine the effects of specific program aspects, particularly those that may be unique to Iowa or private exchanges, we have provided an additional section pulling together the research questions and hypotheses that relate to each area of emphasis.

Non-Emergency Medical Transportation (NEMT)

A special study was undertaken to determine the effects of no longer requiring NEMT be provided under the waiver. The study indicated that IWP members had equal or better access to transportation for health care than MSP members.

All other areas of emphasis were covered within existing hypotheses or additional reports.